MEDICAL & EMERGENCY

CONSENT FORM

Child's Name:

Date: / / (DD/MM/YYYY)

DOB: / / (DD/MM/YYYY)

Emergency Medical Treatment

I, the Parent/Legal Guardian of the above-named child, authorize Little Sprouts Learning Pod to seek emergency medical care, including transportation by emergency services, in the event of an illness or injury while in their care.

I consent to the administration of first aid by Little Sprouts Learning Pod staff and understand that every effort will be made to contact me or the emergency contacts listed. In case I cannot be reached, I authorize medical personnel to provide necessary treatment as deemed appropriate.

Preferred Hospital/Clinic (if any): _____

Primary Physician's Name: _____

Physician's Phone Number: _____

Does your child have any life-threatening allergies? ☐ Yes ☐ No

If yes, please explain: _____

_____

Does your child carry emergency medication? (Check all that apply)

- ☐ EpiPen
- ☐ Inhaler
- ☐ Antihistamine (e.g. Benadryl...)
- ☐ Other, please specify: _____

_____

Emergency Contact

If I, the Parent/Legal Guardian of the above-named child cannot be reached, the name(s) and number(s) listed below are the next trusted to be notified and attempted to reach out by staff:

Name	Relationship (optional)	Phone Number

LEARNING POD

Little sprouts

MEDICATION

AUTHORIZATION FORM

Child's Name:

Date: / / (DD/MM/YYYY)

DOB: / / (DD/MM/YYYY)

Over-the-Counter Medication

Parents/Legal Guardians must supply the following medications, each of which should be in the original container and clearly labeled with the child's name. Staff members must leave initials for records of monitoring and dispensing.

Medication #1 **Staff Initial & Time:**

Medication Name: _____

Dosage: _____

Time(s) to Administer: _____

Start Date/End Date: _____

Reason for Use: _____

Possible Side Effects: _____

Special Instructions: _____

Medication #2 **Staff Initial & Time:**

Medication Name: _____

Dosage: _____

Time(s) to Administer: _____

Start Date/End Date: _____

Reason for Use: _____

Possible Side Effects: _____

Special Instructions: _____

Consent & Agreement

I, the Parent/Legal Guardian of the above-named child, authorize Little Sprouts Learning Pod to seek emergency medical care, including offering assistance through medications.

I consent to the administration of first aid by Little Sprouts Learning Pod staff and understand that every effort will be made to contact me or the emergency contacts listed. In case I cannot be reached, I authorize medical personnel to provide necessary treatment as deemed appropriate.

Parent/Guardian Name: _____ Date: / /

Parent/Guardian Signature: _____