



Rhode Island Department of Human Services

Group/Family Child Care Home: Parent Authorization for Emergency Treatment

Updated 03/20/2020

Authorization Statement	
Child Care Provider/Program Name: _____	
Child's Name: _____	Date of Birth: _____
In consideration of admittance, I hereby authorize _____ <i>Child Care Provider/Program Name</i>	
located at _____ <i>Number and Street</i>	RI _____ <i>City/Town</i> _____ <i>Zip</i>
to arrange for medical examination and/or treatment of my child _____ <i>Child's Full Name</i>	
should an emergency arise while my child is in the care of the above state provider/program. It is understood that a conscientious effort will be made by the provider to contact me at the emergency numbers I have provided below before any medical action is taken.	

Preferred Hospital	
I would prefer my child be taken to the following hospital should the need arise. However, I understand that the choice of hospital may be limited by service of the local rescue.	
Name of Hospital: _____	
Number and Street: _____	State: _____ Zip: _____

Physician and Insurance Information	
I would prefer my child be taken to the following hospital should the need arise. However, I understand that the choice of hospital may be limited by service of the local rescue.	
Name of Doctor: _____	Phone: _____
Health Insurance Carrier: _____	Policy Number: _____

Emergency Contact Information
In the event of an emergency, the child's parent/guardian(s) will be contacted first. In the event the parent/guardian cannot be reached, emergency contact and authorized persons must be listed.
Authorized Person: An authorized person can pick up a child from care with no confirmation from a parent/guardian. An authorized person may also be contacted if the program cannot get ahold of the parent.
Emergency Contact: An emergency contact can pick up a child from care ONLY if there is written and/or verbal communication from the parent. An emergency contact may also be contacted if the program cannot get ahold of the parent.
Please complete the following form listing the authorized and/or emergency contact persons in the order you wish them to be contacted (For example: The first contact listed is the first person that will be called if a parent/guardian cannot be reached).



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Emergency Contact Information			
Full Name:			
Relationship:			<input type="checkbox"/> Authorized Pick Up <input type="checkbox"/> Emergency Contact
Primary Phone:	()	-	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home
Secondary Phone:	()	-	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home

Full Name:			
Relationship:			<input type="checkbox"/> Authorized Pick Up <input type="checkbox"/> Emergency Contact
Primary Phone:	()	-	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home
Secondary Phone:	()	-	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home

Full Name:			
Relationship:			<input type="checkbox"/> Authorized Pick Up <input type="checkbox"/> Emergency Contact
Primary Phone:	()	-	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home
Secondary Phone:	()	-	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home

Parent/Guardian Name (Print)

Relation to Child

Parent/Guardian Signature

Date

Notary

Subscribed and sworn to before me on this _____ day of _____, _____

Date

Month

Year

Notary Public (Print)

Notary Public (Signature)

Commission Expiration