

THE CHILD DEVELOPMENT PROGRAM AT TAFT, INC.

Consent for Treatment

This is to certify that for the period of time in which my child is enrolled, I hereby constitute and appoint The Child Development Program at Taft, Inc. my true and lawful attorney, for the purpose of authorizing medical treatment to, and the performance of any procedure determined to be necessary after consultation with the Emergency Staff and/or Physician; or my child's physician, on my child.

Child's Name _____

Birthdate _____

Allergies _____

Health Problems _____

Child's Physician _____

Physician's Address _____

Physician's Phone _____

If emergency medical treatment is deemed necessary, your child will be transported to Waterbury Hospital via ambulance. One staff member and your child's records will accompany your child to the hospital. Parents will be notified when the child is transported to the hospital.

Parent/Guardian Signature _____ **Date** _____

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