MEDICAL TREATMENT AUTHORIZATION FOR PARTICIPATING MINOR

Must be accompanied by Volunteer Release form signed by parent or guardian

Name of Minor: _____ Date of Birth: _____

Address: _____

Parent or Guardian Contact Info: _____

By my signature below, I represent and warrant to Footsteps child Care that I am the parent or legal guardian of the minor named above. The above-named minor has my permission to participate as a volunteer with Footsteps Child Care. **On behalf of such minor and myself, I have signed a Volunteer Agreement, Assumption of Risk and Release of Liability** (the "Release") and hereby agree to all of the terms and conditions of the Release.

In case of medical or dental emergency, I request that Footsteps Child Care contact me at the telephone number set forth below. However, I hereby give permission to the physician or dentist selected by Footsteps Child Care to hospitalize, treat, secure treatment for, and order injections, anesthesia, X-ray examinations or surgery for the minor named above. A copy of this form may be accepted by and treated by the physician or dentist as the equivalent of the original form.

_____ _____ (____)_____

Date ***Signature of Parent/Guardian*** ***Phone***

_____

Address of Parent/Guardian, if different from address of minor

PLEASE COMPLETE THE FOLLOWING:

1. Medical Insurance Carrier: _____ Policy Number: _____
2. Family Doctor: _____ Telephone: (____)_____
   Address: _____
3. Family Dentist/Orthodontist: _____ Telephone: (____)_____
   Address: _____
4. 4. Drug or food allergies: _____
5. 5. Limitation on activities: _____
6. 6. If I cannot be reached, please contact: _____ Telephone: (_____)_____

Footsteps Child Care, Inc.
374 El Camino Real Belmont, California 94002
T: **650.610.0715** ***F:*** **650.610.0751** ***E:*** **office@footstepschildcare.org** ***W:*** **footstepschildcare.org** ***Tax ID*****: 94-3206278**