

MEDICAL & LIABILITY RELEASE

Name of Doctor _____

Address _____ Phone: _____

Name of Hospital of Clinic _____

Address _____ Phone _____

Name of Dentist _____

Address _____ Phone _____

I understand that in the event medical intervention is needed, if possible, every attempt will be made to contact parents or emergency contacts listed in your registration.

In the event I cannot be reached in an emergency, I hereby give permission to the physician or dentist selected by the Little Harts Preschool staff to secure treatment as deemed medically necessary.

I voluntarily give permission for Little Harts Preschool to administer and/or obtain routine or emergency diagnostic procedures and/or routine or emergency medical treatment for my child as deemed necessary under the circumstances. I will allow emergency medical treatment to be administered as needed. Any further treatment will require parental or guardian consultation and consent. I agree to indemnify and hold harmless Little Harts Preschool and its employees, staff and volunteers for any and all claims, demands, actions, rights of action, and/or judgments by or on behalf of my child and/or me and my spouse, if any, arising from or on account of said procedures and/or treatment rendered in good faith and according to accepted medical standards. I also agree that I will be responsible for any financial debt incurred by the rendering of emergency medical treatment.

I AGREE TO UPDATE THIS INFORMATION IN WRITING AS THE NEED ARISES.

Signature of Parent, Guardian or Managing Conservator

Date