





8550 North Entry Road  
Baldwinsville, NY 13027  
315-635-2815  
www.radissoncommunity.org

## Emergency Treatment Operative Permit

Please complete EITHER the consent (top) OR refusal (bottom).

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In case of emergency, I \_\_\_\_\_,  
(Parent/Guardian)  
Radisson Nursery School, its staff and teachers, the right to give a licensed attending physician or surgeon and/or hospital, permission and consent for emergency treatment and surgery for \_\_\_\_\_.  
(Child's Full Name)

In the event that I am not available when such treatment or surgery is needed, I prefer to have my child taken to \_\_\_\_\_.  
(Name of Hospital)

I have read the above consent and understand the contents thereof:

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Witness Signature)

\_\_\_\_\_  
(Parent/Guardian Printed Name)

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I have read the above consent and will not sign for the following reason(s): \_\_\_\_\_

I understand that the Radisson Nursery School will be held harmless should any doctor or hospital refuse to administer care to \_\_\_\_\_ as a result of my refusal to sign this Emergency Treatment Operative Permit.  
(Child's Full Name)

I have read the above refusal and understand the contents thereof:

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Witness Signature)

\_\_\_\_\_  
(Parent/Guardian Printed Name)



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## Child Information Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M F Nickname: \_\_\_\_\_

Right or Left Handed: \_\_\_\_\_ Sitter Name & Phone: \_\_\_\_\_  
(If applicable during school hours or pickup)

### Family Information

Child lives with: both parents mom dad guardian and/or step parent \_\_\_\_\_

Address: \_\_\_\_\_ Primary Phone: \_\_\_\_\_  
(Street) (City) (Zip)

<b>Mother/ Guardian</b>	Name: _____ Cell: _____ Email: _____ Place of Employment: _____ Work Phone: _____
<b>Father/ Guardian</b>	Name: _____ Cell: _____ Email: _____ Place of Employment: _____ Work Phone: _____

Siblings, Names & Ages: \_\_\_\_\_

Relevant custody information: \_\_\_\_\_

### Health Information

Pediatrician's Name & Number: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies & Treatment: \_\_\_\_\_

Does child receive services for speech, O.T. or P.T.? \_\_\_\_\_ If yes, please explain.

Service(s): \_\_\_\_\_ Agency: \_\_\_\_\_ Start Date: \_\_\_\_\_

Other concerns or Special Needs: \_\_\_\_\_

### Emergency Contact & Transport Information

Parents will be contacted first. At least ONE emergency contract is required.

Name	Phone 1	Phone 2	Relationship	OK to Transport (Yes or No)

\_\_\_\_\_

(Signature of Parent or Guardian)

\_\_\_\_\_

(Date)