

**DIAMOND BAR COMMUNITY PRESCHOOL**  
**EMERGENCY MEDICAL TREATMENT CONSENT & ALLERGY INFORMATION FORM**

As the parent, Agency Representative, or legal guardian of \_\_\_\_\_, I hereby give consent to Diamond Bar Community Preschool to provide all emergency medical or dental care prescribed by a duly licensed physician (MD), Osteopath (DO), or Dentist (DDS). This care may be given under whatever conditions are necessary to preserve life, limb, or the well-being of my child.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Child's known allergies: \_\_\_\_\_

\_\_\_\_\_

Child's dietary restrictions: \_\_\_\_\_

\_\_\_\_\_

Blood type, if known: \_\_\_\_\_

During school hours, I can be reached at: \_\_\_\_\_

Home Phone Number

\_\_\_\_\_

Cell Phone Number

\_\_\_\_\_

Work Phone Number

\*\*\*Please provide a copy of your child's immunization records (yellow immunization card, printed record from medical professional or have physician complete the appropriate section on *Physician's Report – Child Care Centers LIC 701*)\*\*\*