

Springfield College
Child Development Center

715 Wilbraham Road, Springfield, MA 01109
(413) 788-2451



Authorization and Consent Form

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child, _____

(First and Last Name)

However, if I cannot be reached, I hereby authorize the Springfield College Child Development Center to transport my child to the _____ hospital (or nearest hospital)

(Hospital)

and to secure for my child the necessary medical treatment. I understand the teachers at the Child Development Center are trained in the basics of first aid, and I authorize them to give my child first aid when appropriate.

Signature of Parent/Guardian

Date

Parent/Guardian Home: _____

Parent/Guardian Home: _____

Work: _____

Work: _____

Cell: _____

Cell: _____

I hereby authorize the Springfield College Child Development Center to release my child to the following person(s), other than the child's parents/guardians:

1. Name: _____

Relationship: _____

Address: _____ Telephone: _____

2. Name: _____

Relationship: _____

Address: _____ Telephone: _____

Signature of Parent/Guardian

Date