

**BOLTON COOPERATIVE NURSERY SCHOOL, INC.**

**P.O. Box 9233, Bolton, CT 06043-0233**

**Phone: (860) 643-7454**

**MEDICAL RELEASE FORM**

Child's Name: \_\_\_\_\_

Child's Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

In the event of an emergency situation and Bolton Cooperative Nursery School is unable to reach a parent/legal guardian, the school may release the child to the following person(s):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

I give my consent for the Bolton Cooperative Nursery School to contact my child's named physician if my child has a medical emergency. I understand that if my child's physician is not available, another physician may be contacted on an emergency basis. I also give my consent for the Bolton Cooperative Nursery School to seek medical attention in an emergency at the facility of their choice. I will be responsible for all medical charges.

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Insurance: \_\_\_\_\_

Does your child have any allergies (bee stings, medications, foods, etc.)?

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

SIGNATURE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_

DATE: \_\_\_\_\_