Reset Form

Ohio Department of Job and Family Services

EMERGENCY TRANSPORTATION AUTHORIZATION DENTAL AND MEDICAL PLAN

Child Care Centers/Type A Family Child Care Homes/Type B Family Child Care Homes/In-Home Aides

Complete this form for each child and update as needed:

Name of Child	Mother's Name		Father's Name	
Street Address	Home Address		Home Address	
City, State, and Zip Code	City, State, and Zip Code	Phone Number	City, State, and Zip Code	Telephone Number
Telephone Number	Employer's Name		Employer's Name	
Lists names of additional children in care: _____ _____ _____ _____ _____	Employer's Street Address		Employer's Street Address	
	City, State, and Zip Code	Telephone Number	City, State, and Zip Code	Telephone Number
	If not at home or work, give school telephone number or other telephone number where parents can be reached, if different from above: Mother _____ Father _____			

Name of Child's Physician or Clinic		Name of Child's Dentist or Clinic	
Street Address		Street Address	
City, State, and Zip Code	Telephone Number	City, State, and Zip Code	Telephone Number

List two people who can be contacted in an emergency if the parent cannot be reached:

Name		Name	
Street Address		Street Address	
City, State, Zip Code		City, State, and Zip Code	
Relationship to Child	Telephone Number	Relationship to Child	Telephone Number

Part I <u>OR</u> Part II must be completed. Do not complete both. Part III and IV must be completed.

This form only authorizes the child care facility to secure emergency transportation for a child. This form does not authorize or guarantee treatment upon arrival at the designated source of emergency care. The facility establishes its own treatment procedures.

Part I. Permission to Transport Child

I give_____permission to transport my child_____
(Name of child care facility, type B home provider, in-home aide, emergency/substitute caregiver) (Name of child)

to_____ for emergency medical care, or to_____ for emergency
(Name of emergency care facility) (Name of dentist, dental clinic)
dental care to the nearest available source of assistance.

Parent's Signature	Date

Part II. Refusal to Grant Permission to Transport Child

I do not give permission to _____ to transport my child _____
(Name of child care center, type B home provider, in-home aide, emergency/substitute caregiver) (Name of child)

for emergency medical or dental care. In the event of an illness or injury which requires emergency medical or dental treatment, I wish the following action to be taken: _____

_____

_____

_____

Parent's Signature	Date

Part III. Describe the Emergency Dental Plan

_____

_____

_____

_____

_____

Part IV. Describe the Emergency Medical Plan

_____

_____

_____

_____

_____

This form is used by child care centers, type A homes, type B homes and in-home aides to meet the requirements of chapters 5101:2-12, 5101:2-13 and 5101:2-14 of the Administrative Code.

Distribution for centers and type A homes: Original to center; copy to parent.
Distribution for in-home aides: Original to county agency; copy to in-home aide, copy to parent.
Distribution for type B homes: Original to provider, copy to county, copy to parent.