

**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 OR 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
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**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
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**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.