Transportation

Program **2018 – 2019**

STUDENT EMERGENCY INFORMATION

Is anyone legally restricted from being in contact with your child? ❑ Yes ❑ No

If yes, who? _____

(*Place legal documentation in Family File*)

	Child's Name (Last, First)		
	Birth Date (Child)	Center	
	Home Address		
	Parent/Guardian 1	Relationship	
	Parent/Guardian Primary Language		
	Phone # (Home)	Phone # (Message/Cell)	
	Parent/Guardian 2	Relationship	
	Phone # (Home)	Phone # (Message/Cell)	
	Daycare Provider		
	Daycare Contact Name	Daycare Phone	
Medical Emergency Contact Name (Last, First)	Relationship to Child	Phone	
Child's Doctor	Phone # (Doctor)	Hospital Preference	
List Medications (if any)	Medical Problems/Allergies		
Special Circumstances:	Date of last DPT	Number of Last DPT	
Name of Insurance Company	Insurance ID #		
Child's Dentist	Phone # (Dentist)		

I hereby give permission for my child's photo to be on file with the PSESD Transportation Program.

I hereby give permission that my child may be given emergency treatment to include first aid and CPR by a qualified staff member. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by my child's regular health care provider, or when that health care provider cannot be reached, by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted.

I also give permission for my child to be transported by ambulance, aid car or the above-named alternate persons to an emergency center for treatment. If my child becomes ill or injured at ECEAP/Head Start and I or the above-mentioned alternates cannot be reached or provide transportation for my child, I give permission for my child to be transported home as usual by school district or ECEAP/Head Start transportation.

Signature of Parent/Guardian Date Signature of Interpreter Date