

Emergency Treatment and Consent Form

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

If yes, name of person(s): _____

(STAFF: request a copy of legal documentation)

Photo of Child (Optional)	Child's Name:
	Date of Birth:
	Center/Site Name:
	Child's Home Address:
	Transportation: <input type="checkbox"/> Car/walk <input type="checkbox"/> Bus (if applicable to your program - STAFF: Write bus information here when available)

	Parent/Guardian 1	Parent/Guardian 2
Name:		
Relationship to Child:		
Primary Language(s):		
Interpreter Needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Phone Number:	_____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	_____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Alternate Phone Number:	_____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	_____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Email Address:		
When is the best time to reach you?	<input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings <input type="checkbox"/> Anytime	<input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings <input type="checkbox"/> Anytime
What is the best way for us to communicate with you?	<input type="checkbox"/> Note in child's backpack <input type="checkbox"/> Phone call <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Face-to-face	<input type="checkbox"/> Note in child's backpack <input type="checkbox"/> Phone call <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Face-to-face
Where would you prefer to meet for family support visits and parent-teacher conferences?	<input type="checkbox"/> Home <input type="checkbox"/> Center/Site (if applicable) <input type="checkbox"/> Other – discuss the specific place with the staff	<input type="checkbox"/> Home <input type="checkbox"/> Center/Site (if applicable) <input type="checkbox"/> Other – discuss the specific place with the staff

Name of Emergency Medical Contact:	Relationship to Child:
Address:	Business/home phone:
Medical conditions/allergies, if any:	Medications:
Child's insurance:	Insurance ID #:

Child's Health Care Provider:	Phone:
Address:	

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Child's Name:

Child's Dentist:	Phone:
Address:	

Child's Child Care Provider, if applicable:	
Address:	Phone:

I give permission for my child to be released to the following people for the current program year.
(People listed below must show proper identification before your child will be released from the center or the bus.)

Name	Relationship to Child	Phone Number

The following sibling/other child, at least the age of 12 years, may receive my child from the center/bus, if applicable.
(People listed below must show proper identification before your child will be released from the center or the bus.)

Name	Relationship to Child	Phone Number

If initialed, this means I give consent for the following while my child is enrolled in this Early Learning Program:

Consent for Services

- | | |
|---|---|
| <input type="checkbox"/> Transportation to/from the center, when/if available
<input type="checkbox"/> Developmental screenings and assessments so staff know if my child is developing on schedule
<input type="checkbox"/> Health screenings (check eyes, hearing, height and weight)
– complete <i>Declining Early Learning Health Services Form</i> if not initialed
<input type="checkbox"/> Dental screenings (check teeth and gums) | <input type="checkbox"/> Mental Health consultation
<input type="checkbox"/> Access to State Child Profile immunization record
<input type="checkbox"/> Photograph or video to help train staff
<input type="checkbox"/> Photograph or video to build partnerships with community agencies |
|---|---|

For your child's safety: your signature below grants trained Early Learning staff permission to provide your child with emergency treatment including First Aid and CPR. When deemed immediately necessary, medical, surgical and hospital care, treatment, and procedures will be provided by your child's regular health care provider, or by a licensed physician or hospital, if your regular health care provider cannot be reached. If you cannot be reached, transportation will be provided by ambulance, aid car, or by any of the people named above to an emergency center for treatment.

Parent/Guardian Signature

Date

Interpreter Signature

Date