Emergency Treatment and Consent Form

Early Learning psesd excellence & equity in education Puget Sound Educational Service District

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: ☐ Car/walk ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No
Phone Number:	_____ ☐ Cell ☐ Home ☐ Work	_____ ☐ Cell ☐ Home ☐ Work
Alternate Phone Number:	_____ ☐ Cell ☐ Home ☐ Work	_____ ☐ Cell ☐ Home ☐ Work
Email Address:		
When is the best time to reach you?	☐ Mornings ☐ Afternoons ☐ Evenings ☐ Anytime	☐ Mornings ☐ Afternoons ☐ Evenings ☐ Anytime
What is the best way for us to communicate with you?	☐ Note in child's backpack ☐ Phone call ☐ Text ☐ Email ☐ Face-to-face	☐ Note in child's backpack ☐ Phone call ☐ Text ☐ Email ☐ Face-to-face
Where would you prefer to meet for family support visits and parent-teacher conferences?	☐ Home ☐ Center/Site (if applicable) ☐ Other – **discuss the specific place with the staff**	☐ Home ☐ Center/Site (if applicable) ☐ 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:	

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. No child will be released to a person under the age of 18 regardless of whether or not the local school district/agency allows for release to a younger person.)

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

_____ Transportation to/from the center, when/if available

_____ Developmental screenings and assessments so staff know if my child is developing on schedule

_____ Health screenings (check eyes, hearing, height and weight) **– complete *Declining Early Learning Health Services Form* if not initialed**

_____ Dental screenings (check teeth and gums)

_____ Mental Health consultation

_____ Access to State Child Profile immunization record

_____ Photograph or video to help train staff

_____ 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**