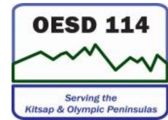
Olympic Educational Service District 114



105 National Avenue North, Bremerton, Washington 98312
(360) 478-6887 ● 1-800-201-1300 ● FAX (360) 405-5808

Olympic ESD Head Start / ECEAP / Early Head Start

EMERGENCY CARE FORM

Child ____________________________________ B/D ________________ Site __________________ A/M or P/M

Address ___________________________________ City/Zip_____________________ Home # _________________

Parent(s) _______________________________ Work # _________________ Msg./Cell Phone #________________

Employer Name & Address____

Emergency Contacts & Permission for Pick-up

If there is an emergency and I cannot be reached, please call the people listed below. I also give permission for each of them to pick up my child from Head Start/ECEAP/Early Head Start. ☑ In the event of an earthquake or other disaster, I am including the name of a person who does not need to cross a bridge to get to the classroom. ☑ I also understand that if my child's classroom is located in an elementary school building or if my child receives transportation services, the following information will be shared with school district and building staff as necessary.

Name (Local person) *Address* *Phone#* *Relationship*

____

____

Name (out of state person) *Address* *Phone#* *Relationship*

____

Health Status

Allergies____

Ongoing Medical/Health Conditions____

Medical Coverage _________________________________ Preferred Hospital _______________________________

Current Medications ____

Doctor___________________________/____/________________
Address Phone

Dentist___________________________/____/________________
Address Phone

Emergency Treatment Consent

Please read the following statements and *initial each section* to indicate your understanding and consent:

_____ I give permission for my child to receive emergency first aid from qualified staff or emergency medical personnel if deemed necessary by Head Start/ECEAP staff.

____ In an emergency, if deemed necessary by program staff, I give Head Start/ECEAP permission to arrange transportation for my child by rescue squad or ambulance to a licensed physician, clinic or emergency room of an accredited hospital.

____ In the event that I cannot be contacted, I further consent to medical, dental, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, dentist, or hospital when deemed necessary or advisable by the physician to safeguard my child's health.

☐ **Special Instructions** ☐ **Restraining Order** (If either checked, highlight or explain on attached paper.)

Parent/Legal Guardian Signature ____ Date________________