Olympic Educational Service District 114
105 National Avenue North, Bremerton, Washington 98312
(360) 478-6889 ● 1-800-201-1300 ● FAX (360) 405-5808
Olympic ESD Early Learning

EMERGENCY CARE FORM

Childs Full Name: _____ Birthdate: _____ Site _____

Address _____ City/Zip_____ Cell # _____

Parent(s) _____ Work # _____ Home #_____

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 (to child)*

_____

_____

Name (out of state person if possible) *Address* *Phone#* *Relationship (to child)*

_____

Health Status

Allergies_____

Ongoing Medical/Health Conditions_____

Current Medications _____

Medical Coverage _____

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 OESD 114 Early Learning staff.

____ In an emergency, if deemed necessary by program staff, I give OESD 114 Early Learning 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, review details with family, add to Pick Up Alert and obtain documents.)

Parent/Legal Guardian Signature _____ Date_____