

KCR Early Learning and Family Services
Early Head Start/ Head Start/ ECEA Programs
Emergency Card

PLEASE SUBMIT A NEW FORM FOR ANY UPDATES OR CHANGES, OTHERWISE EVERY 90 DAYS

Child: _____ / _____ D.O.B: _____ Site: _____
Last First

Address: _____ City/Zip: _____ Home Phone: _____

PARENT/GUARDIAN #1 at above address

First Name Last Name

Relationship to Child: _____

Cell Phone: _____

Work Phone: _____

PARENT/GUARDIAN #2 at above address

First Name Last Name

Relationship to Child: _____

Cell Phone: _____

Work Phone: _____

Emergency Contacts & Permission for Pick-up

If there is an emergency and I/We cannot be reached, please call the people listed below. I/We also give permission for each of them to pick up my child.

<i>First & Last Name</i>	<i>Relationship to Child</i>	<i>Address</i>	<i>Phone Number(s)</i>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Out of State Contact

<i>First & Last Name</i>	<i>Relationship to Child</i>	<i>Address</i>	<i>Phone Number(s)</i>
_____	_____	_____	_____

Under NO circumstances should the following person(s) be given information or have contact with my child.

Name: _____ Relationship to Child: _____
Is there a restraining order on file? Yes or No Special Instructions? Please explain on reverse side of this page

Health Status

Allergies/Restrictions/Medications/Conditions: _____

Doctor: _____ Phone: _____ Address: _____
Dentist: _____ Phone: _____ Address: _____
Hospital: _____ Phone: _____ Address: _____

Emergency Treatment Consent

I give my permission for Kitsap Community Resources Head Start/Early Head Start/ECEAP to administer first aid to my child if the need arises. I give permission for Kitsap Community Resources Head Start/Early Head Start/ECEAP to call 911 to obtain emergency medical care for my child in the event of serious injury. In the event I cannot be contacted, I consent to the medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health. In such an emergency, I give permission for Kitsap Community Resources Head Start/Early Head Start/ECEAP to determine the best method of transportation.

Signature of Parent/Guardian _____ Date _____