



Emergency Consent and Medical Information Release Form

Name of Child:	Birth Date:	Gender:
Address:	School:	
Student Social Security :	Teacher:	

In the event that I cannot be reached to make arrangements for medical attention for my child, at the time of an accident or illness while he or she is attending a Head Start program, I grant and authorize a representative of Head Start to grant permission to the medical staff and the Emergency Department staff of the local hospital to perform any medical or surgical treatment and to administer such anesthesia and/or drugs as may be deemed necessary in the diagnosis or treatment of said patient. Furthermore, I hereby authorize release of all medical/dental pertinent information concerning my child to a designated representative of Head Start.

We the parent(s)/guardian(s) of the above named child acknowledge it is our responsibility to keep the information in this Emergency Consent form current and correct. We agree to notify Head Start of any changes to phone numbers or changes of physician or changes in name of those who shall be contacted in the event of any emergency.

Medications Taken By Child: _____

Child's Allergies: _____

Chronic Diseases: _____

Child's Doctor: _____

Child's Dentist: _____

 Signature of Parent/Guardian

 Date

 Home Phone

 Work Phone