



TRANSPORTATION ENROLLMENT

Child _____ Date of Birth _____

Name _____ Address _____ Phone _____

Mother _____ Work _____ Phone _____

Father _____ Work _____ Phone _____

Address of deliver, if other than above _____

Persons, other than parent/guardian to notify in case of emergency:

Name	Address	Relationship	Phone
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

I authorize my child to be released to the following people: *(must be 18 years or older)*

1. _____
2. _____
3. _____

_____ **AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT:**
 If required, I hereby authorize the Head Start Teacher and/or Staff to get medical aid for my child _____ from my child's physician, hospital emergency room staff emergency medical technicians, or the center nurse, if they are unable to contact me or other legal guardian. My hospital of choice is _____. I understand that, if required, the nearest hospital available to provide the needed emergency service will be used.

 Signature of Parent/Legal Guardian

 Date

 Signature of Head Start Authorized Staff

 Date