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

Emergency Card

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: _____
Employer: _____

PARENT/GUARDIAN #2 at above address

_____
First Name *Last Name*
Relationship to Child: _____
Cell Phone: _____
Work Phone: _____
Employer: _____

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.

First & Last Name	*Relationship to Child*	*Address*	*Phone Number(s)*
1.			
2.			
3.			

Out of State Contact

First & Last Name	*Relationship to Child*	*Address*	*Phone Number(s)*

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_____

SCAN AND UPLOAD TO CHILDPLUS: Child's Application Section White Copy
White Copy: Child File Yellow Copy: Emergency Binder