Emergency Consent:
Authorization for Medical Care for Minor Child

Child Name:_____ Date of Birth:_____

In the event of an emergency affecting your child, **ARVAC Head Start and Early Head Start** will make every attempt to contact you. In unusual circumstances, however, we may need to act immediately to protect your child. **We need your permission to do so.** *Please initial next to each item, then sign below.*

1. I give permission to to **ARVAC Head Start and Early Head Start** to take emergency measures (e.g. first aid, disaster evacuation) as judged necessary for the care and protection of my child while under the supervision of the center. *Initials:* _____

2. I give permission for my child to receive X-rays, examinations, anesthesia, and/or medical, surgical or dental treatment and care, under the supervision of a licensed physician, dentist or surgeon, when the need for such treatment is immediate and I cannot be reached. *Initials:* _____

3. In case of a medical emergency, I give permission for my child to be transported to an appropriate medical facility for treatment if the local emergency resources (police, rescue squad, ambulance) deem it necessary. I understand that these transportation expenses will be my responsibility as the child's parent/guardian. *Initials:* _____

4. In the event that my child's center needs to be evacuated, I give permission for my child to be transported to another nearby location. I understand that I will be informed by telephone at the earliest possible opportunity. *Initials:* _____

5. I understand that in some medical situations, the staff will need to contact the local emergency resources before the parent, child's physician, and/or other adults acting on the parent's behalf. *Initials:* _____

This form must be signed by the child's parent or legal guardian.

Signature_____ **Date** _____

Print Name_____ **Relationship to Child** _____

To be completed by **ARVAC Head Start and Early Head Start staff***:*

Physician Name:_____ Phone Number:_____

Dentist Name:_____ Phone Number:_____

Allergies:_____

Medical condition(s) that could be relevant in an emergency: _____

_____

Signature of Staff:_____ Date:_____