PRIME TIME Head Start

Emergency Consent:
Authorization for Medical Care for Minor Child

Child Name: ____ Date of Birth:__________________

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

T***yping your INITIALS*** in the lines provided, is the same as ***signing your initials.***

1. I give permission to **PRIME TIME® 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** __________________

Typing your First and Last Name in the Signature Block above, acts as your signature.

To be completed by: **PRIME TIME® Head Start**

Physician Name:____Phone Number:__________________

Dentist Name:____Phone Number:__________________

Allergies:____

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

____

Signature of Staff:______________________________________ Date:____________________

SAVE this document where you can find it and EMAIL it to enroll@primetimefamily.org.

The original will be kept in the child's file with a copy of this form in the classroom.