Central Montana Head Start

204 7th Avenue West
Roundup, MT 59072
(406)323-3655
(406)323-4255-fax

25 Meadowlark Lane
Lewistown, MT 59457
(406)535-7751
(406)535-7752-fax

304 East Division
Harlowton, MT 59036
(406)632-4382
(406)632-4416-fax

Child Emergency Data Sheet

Child's Name: _____ Date: _____
Address: _____
Is this an address change? Yes No **Is this a phone number change? Yes No**

People to contact in emergency. People authorized to pick up.

Contact's Name & Relationship to child	Phone #	Work Place & Phone #	Emergency Contact	Authorized Pickup
			Y N	Y N
			Y N	Y N
			Y N	Y N
			Y N	Y N
			Y N	Y N

☐ **UNAUTHORIZED CONTACT: _____**
*****MUST be accompanied by court documentation*****

Child Care Information:

Name: _____ Phone: _____

Relationship to child: _____ Phone: _____

***If parent/guardian is not home, or does not pick up child by the designated time the child will be taken to a designated Child Care and the parent/guardian will be responsible for charges.**

Person Authorized to make schedule changes:

Name: _____ Phone: _____

Relationship to child: _____ Phone: _____

☐ **I give permission for Central Montana Head Start, Inc. to send mailings to my child's non-custodial parent/guardian.**

Name: _____ Address: _____
Relationship to child: _____ _____

Child's Insurance Coverage:

_____ Medicaid _____ CHIP _____ Private Insurance _____ None

Medicaid/Insurance #: _____

Name of Insurance: _____

Medical Provider's Information:

Name: _____ Phone: _____

Address: _____

ALLERGIES: _____

_____

*Allergies must be confirmed by a health care provider (such as food, medications, animals, dust etc.)

HEALTH CONDITIONS: _____

_____

* Please list any health conditions your child has that may affect his/her treatment in an emergency (such as asthma, seizures, etc.)

Dental Provider's Information:

Name: _____ Phone: _____

Address: _____

Optometrist's Information:

Name: _____ Phone: _____

Address: _____

TRANSPORTATION PERMISSION AUTHORIZATION: I hereby authorize any employee of Central Montana Head Start, Inc. to transport or take the above mentioned child on field trips and outings as the program may deem entertaining or educational. At the end of the day, or during the day, my child may be released only to the person(s) signing this form or the above listed pickup person(s). In the event no authorized person is available, I understand I may call and inform you of another person.

SPECIAL INSTRUCTIONS: I, undersigned parent or guardians, hereby give my consent for emergency medical or dental treatment of my child by any licensed physician or dentist while under the care of the program child care provider and for transport of my child to and from the source of emergency treatment. This care may include examinations and/or any tests, which, in the opinion of the physician or dentist are deemed necessary or advisable. This does not include the right to perform surgical operations without further consent, except in the case of a life threatening emergency and when, after an effort has been made to locate me, I am found to be unavailable.

I, the parent or guardian, do hereby authorize, request and direct the program to render such emergency treatment to said minor as judged advisable. **This consent is valid for the year my child is enrolled in the program. The purpose of this consent form has been explained to me.**

SIGNATURE OF PARENT(s) OR GUARDIAN(s) **DATE**

INTERVIEWING STAFF PERSON **DATE**