EASTCONN Where Learning Comes to Life EARLY HEAD START

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EMERGENCY CONTACT SHEET

Child's Name: ______________________ Primary Adult: ______________________

☐ EHS ☐ HS Site: ______________________ Address: ______________________

Date of Enrollment: __________ 45 Days: __________ Phone: ______________________

Child's Address: ______________________ Email: ______________________

Child's Phone: ______________________ Employer, Address & Phone: ______________________

Birth Date: __________ Place of Birth (State): __________ ______________________

Sex: __________ Race: __________ Hours of employment: ______________________

Height: __________ Weight: __________ Date: __________ Secondary Adult: ______________________

Color of Hair: __________ Color of Eyes: __________ Address: ______________________

Child's Primary Language: ______________________ Phone: ______________________

Health Insurance #: ______________________ Email: ______________________

Child's Physician: ______________________ Employer, Address & Phone: ______________________

Physician Phone #: ______________________ ______________________

Child's Dentist: ______________________ Hours of employment: ______________________

Dentist Phone #: ______________________ Primary Language of Parents: ______________________

Hospital Preferred: ______________________Town/location: ______________Phone #: ______________

Any identifying marks on the child: ______________________

Allergies to Food (specify): ______________________ Reaction: ______________________

Allergies to Medicine (specify): ______________________ Reaction: ______________________

Allergies to Anything else (specify): ______________________ Reaction: ______________________

List any medication(s) the child may be taking: ______________________

List any concerns (health/psychological): ______________________

☐ YES ☐ NO – My Family agrees to receive text messages and/or emails from EASTCONN EHS & HS

I give permission for the following people, who are 18 years of age or older, to be contacted in case of emergency, if I cannot be reached. These same people and/or Head Start staff also has my permission to transport my child from the center to wherever deemed necessary. In the event of an emergency or the need for medical attention concerning my child, I hereby authorize EASTCONN Head Start, its agents, and staff to take whatever action they deem necessary, in their best judgment, to and including taking my child to the hospital, doctor, dentist or other medical specialist in a private car, Head Start vehicle or ambulance. In addition, the contacts listed are authorized to pick up my child at Head Start or from the Head Start bus. Contacts must provide a photo identification.

Yo le doy permiso a las siguientes personas, que tienen 18 años de edad o más, para comunicarse con ellas en caso de emergencia, sino puedo ser localizado. Estas mismas personas y/o el personal de Head Start tambien tienen mi permiso de recoger mi niño/a a del centro a cualduier sitio que sea necesario. En cualquier evento de emergencia o en la necesidad de asistencia médica concerniente a mi niño/a, por la presente, yo autorizo EASTCONN Head Start sus agents, y el personal de tomar cualquier acción que juzgen necesaria, en su mejor juicio, e incluyendo llevando mi niño/a al hospital, doctor, dentista, u otro médico especialista, en un automóvil privado, vehículo de Head Start o ambulancia. Además, los contactos enumerados están autorizados a recoger a mi hijo en Head Start o desde el autobús de Head Start. Los contactos deben proporcionar una identificación con foto.

Person(s) to contact in case of emergency. Please use back if additional emergency contacts.

1. Name: ______________________
   Relationship: ______________________
   Address: ______________________
   Telephone: ______________________
2. Name: ______________________
   Relationship: ______________________
   Address: ______________________
   Telephone: ______________________
3. Name: ______________________
   Relationship: ______________________
   Address: ______________________
   Telephone: ______________________
4. Name: ______________________
   Relationship: ______________________
   Address: ______________________
   Telephone: ______________________

***Emergency Contact* Sheet may be re-signed if there are no changes. If any changes are needed, please complete a new form.**

Signature of Parent(s)/Guardian: ______________________ Date: __________

Signature of Parent(s)/Guardian: ______________________ Date: __________

Signature of Parent(s)/Guardian: ______________________ Date: __________

Signature of Parent(s)/Guardian: ______________________ Date: __________

9-2019