FDS
3 Copies to Lead Teacher
1 Copy to Bus Transporters

Community Action of Southeast Iowa Head Start/Early Head Start

EMERGENCY MEDICAL RELEASE

*This form is to go with child if transported for emergency care

Child's Full Name_____ **Date of Birth**_____
First Middle Last

Sex of Child: ☐ **Male** ☐ **Female** **Parent/Guardian** _____

Physician_____ **Physician Telephone Number**_____

Dentist_____ **Dentist Telephone Number**_____

As parent or legal guardian, I give my permission for my child to receive emergency medical or dental care provided by a local doctor, dentist, or emergency room physician. In addition, I authorize Community Action of Southeast Iowa Head Start/Early Head Start staff to administer first aid to my child as deemed necessary.

I agree to pay the entire costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent. Every effort will be made to notify parent/guardian immediately in case of emergency. This form will be presented upon admission for treatment.

Allergies to medications or food: _____

Medications child is currently taking: _____

Insurance Company_____ **Policy Holder's I.D.**_____

Religious Preference (optional) _____

_____ __/__/__ _____ __/__/__
Signature Parent/Guardian Date Signature Staff Witness Date

_____ __/__/__
Nurse Signature Date

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