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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