

The following form(s) can be filled in on-line, then printed for signatures and mailing or faxing.

To begin filling out the forms in Acrobat Reader, make sure the **hand** tool is selected then click on a line or in a box and begin typing. Check boxes can be clicked on or off.



# Spokane County Head Start/ECEAP/EHS

FAMILY CODE WORD

(OPTIONAL)

## RELEASE AND EMERGENCY TREATMENT AUTHORIZATION

Child's name \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Mother \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Father \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

### I GIVE MY PERMISSION FOR MY CHILD TO HAVE:

YES NO

First aid and/or emergency medical care including transportation (If no, parent must remain on school premises.)

Emergency blood transfusion (When condition is life threatening and parent cannot be reached.)

Emergency surgery (When condition is life threatening and parent cannot be reached.)

### EMERGENCY INFORMATION

Doctor's name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Dentist's name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Severe allergies such as bee stings, food, etc. \_\_\_\_\_

Medical alert \_\_\_\_\_

If parent or guardian cannot be reached, contact or release my child to:

Name/relationship \_\_\_\_\_ Name/relationship \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Home phone \_\_\_\_\_ Home phone \_\_\_\_\_

Work phone \_\_\_\_\_ Work phone \_\_\_\_\_

### RELEASE INFORMATION

**Head Start/ECEAP/EHS cannot refuse to release a child to her/his parents without a copy of a court order.** I understand that my child's file is available to either parent to review at any time. This information is confidential except to appropriate Head Start/ECEAP/EHS staff and consultants, unless I give permission to release it.

Do not release my child to \_\_\_\_\_

Protection Order No. \_\_\_\_\_ Expiration date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parenting Plan in file. Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Remember to notify Head Start/ECEAP/EHS of any changes to the above information**

### EMERGENCY TREATMENT AUTHORIZATION

In the case of a serious medical emergency my child \_\_\_\_\_

may be treated by any physician at \_\_\_\_\_ Hospital

(or the nearest medical facility if there is a life threatening emergency.)

Parent's signature \_\_\_\_\_ Date \_\_\_\_\_

Witnessed by \_\_\_\_\_ Date \_\_\_\_\_

**VALID FOR ONE YEAR FROM DATE OF SIGNING**

**Parent or guardian may revoke this authorization in writing at their discretion**

White—Emergency Notebook

Yellow—File Copy

Pink—Parent