



FAMILY CODE WORD _____

Spokane Colleges Head Start & ECEAP Release And Emergency Treatment Authorization

(OPTIONAL) _____

Child's name _____ Birth date _____
Address _____ City _____ ZIP _____
Parent/Guardian _____ Home Phone _____ Work Phone _____ Cell Phone _____
Parent/Guardian _____ Home Phone _____ Work Phone _____ Cell 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 _____ Clinic Name _____ Phone _____
Doctor's name _____ Clinic Name _____ Phone _____
Severe allergies such as bee stings, food, etc. _____
Medical alert _____
If parent or guardian cannot be reached, contact or release my child to: _____

EMERGENCY TREATMENT INFORMATION

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.)

EMERGENCY CONTACTS

Name _____	Relationship _____
Phone Numbers _____	
Name _____	Relationship _____
Phone Numbers _____	
Name _____	Relationship _____
Phone Numbers _____	
Name _____	Relationship _____
Phone Numbers _____	
Name _____	Relationship _____
Phone Numbers _____	

RELEASE INFORMATION

Spokane Colleges Head Start & ECEAP cannot refuse to release a child to their 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 Spokane Colleges Head Start & ECEAP 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 Spokane Colleges Head Start & ECEAP of any changes to the above information

Parent's signature _____ Date _____
Witnessed by (HS/ECEAP Staff) _____ Date _____

AUTHORIZATION IS VALID FOR PROGRAM YEAR
Parent or guardian may revoke this authorization in writing at their discretion.

Route 3 (Emergency Notebook, File Copy, Parent Copy)