Community Colleges of Spokane

Spokane Head Start MS 1055 ▪ 3939 N. Freya St. ▪ Spokane WA 99207
(509) 533-4800 ▪ FAX (509) 533-4850

Spokane Head Start/ECEAP/EHS
POLICY COUNCIL CHILD CARE INFORMATION FORM

Dear Parent,

Thank you for your interest in Policy Council! To better serve the needs of your family, it is requested that you complete the following information. All information will be kept confidential and will only be used to ensure the health and safety of your child while attending Policy Council child care at Northeast Community Center.

PLEASE PRINT LEGIBILY

PARENT(S) NAME: _____
First *Last*

PHONE NUMBER: _____ HS/ECEAP/EHS SITE: _____

CHILD'S NAME FIRST	LAST	D.O.B.	ALLERGIES/ SPECIAL DIET	SPECIAL DIET SUBSTITUTIONS*
Example Max	Snyder	2/15/13	YES NO Lactose intolerant	Soy milk to drink
			☐ ☐	
			☐ ☐	
			☐ ☐	
			☐ ☐	
			☐ ☐	

**If more space is needed please use the back of this form.*

EMERGENCY CONTACT NAME: _____
First *Last*

PHONE NUMBER: _____

EMERGENCY TREATMENT AUTHORIZATION
I give my permission for my child to have:

YES	NO	
☐	☐	First aid and/or emergency medical care including transportation
☐	☐	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)

In the case of a serious medical emergency my child may be treated by a physician at the hospital noted (or the nearest facility if there is a life-threatening emergency.) _____

PARENT'S SIGNATURE: _____ DATE: _____