COMMUNITY CHILD CARE CENTER

Head Start/EHS/ECEAP/Child Care

FOR OFFICE USE ONLY
DEPOSIT PAID $_____DATE_____
DISENROLLMENT DATE_____
❑ FOOD ALLERGY
❑ HEALTH CONDITION
❑ SOCIAL / FAMILY CONCERN

EMERGENCY AND MEDICAL INFORMATON FORM

Child's Name _____ Birthday _____ Gender_____ Start Date_____

School Age Children Only_____
School Grade

Primary residence of child is with: _____ _____

Are there any court orders/parenting plans in effect concerning the custody of the child? **□Yes** **□No**
If so, please provide us with a copy of these documents prior to enrollment.
Is your family currently involved with the State of Washington Department of Children, Youth & Families (CPS)?
□ Yes **□ No**

_____ (___)_____ _____ (___)_____ _____
Legal Guardian Name Home Phone Cell Phone Email Address

_____ (____)_____
Address of Guardian Place of Employment Work Phone

_____
The best way to reach me (i.e. email, text, phone call) The best time to reach me

_____ (__)__ _____ (__)_____ _____
Legal Guardian Name Home Phone Cell Phone Email Address

_____ (____)_____
Address of Guardian Place of Employment Work Phone

_____
The best way to reach me (i.e. email, text phone call) The best time to reach me

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Local Emergency Contacts (These persons are authorized to pick up the child):

1._____ (____)_____
Name Relationship to Guardian Phone Number(s)

2._____ (____)_____
Name Relationship to Guardian Phone Number(s)

Physician/Dentist Information:

_____(___) _____(___)_____
Physician Name Phone Last Appt. Date Dentist Name Phone Last Appt. Date

*(if you do not have a Doctor or Dentist please let our staff know and we can provide you with a list of local providers)

Medical Insurance Information:

Company: _____Plan Number: _____

Allergy & Medical History

Allergies, medication/medical conditions_____ **If none, check here** _____

Permission for Emergency Treatment

At the time of an emergency, medical treatment is urgent. I authorize Community Child Care Center staff to call emergency aid (911) or transport my child to the nearest hospital or my child's physician to receive immediate care. I also give permission for CCCC to give first aid for minor injuries. I understand that I will be responsible for all expenses connected with the seeking of emergency care.

Signature _____ **Date**_____