COMMUNITY CHILD CARE CENTER

530 NW Greyhound Way Pullman WA, 99163

ECEAP Early Childhood Education & Assistance Program
Washington State Department of Children, Youth & Families

Head Start/EHS/ECEAP

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

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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** _____