Stanislaus County Office of Education
Tom Changnon, Superintendent

Child & Family Services

Tony Jordan, Executive Director
1100 H Street • Modesto CA 95354 • (209) 238-1800 • FAX (209) 238-4217

CHILD/FAMILY SERVICES EMERGENCY CARD

Service Options: ____ Center Based
____ Home Based ____ FCCH ____ CAPP

Location_____

Phone_____

Teacher_____

MEDIC ALERT Health Concern ☐ Yes ☐ No
(Asthma, Allergies, Medications, Health Problems: List _____ **)**

Is there a court order regarding custody of the child? ☐ Yes ☐ No

Child's Name _____
(Last) (First) (MI) (DOB)

Primary Language Spoken
At Home _____

Mailing Address _____
(Street Address)

_____
(City) (State) (Zip)

Physical Address _____
(Street Address)

_____
(City) (State) (Zip)

Mother/Guardian _____
(Last) (First) (DOB)

Home Phone _____
Work Phone _____
Cell Phone _____

Father/Guardian _____
(Last) (First) (DOB)

Home Phone _____
Work Phone _____
Cell Phone _____

Child's Doctor/Hospital to be called in case of emergency _____

Doctor's Phone _____

Address _____

MediCal - Healthy Families - None - Private (name) _____ (circle one)

Child's Insurance #_____

Permission for Medical Treatment: As the child's parent or legal guardian, I understand that in the case of my child's medical emergency, the center will call 911 and then notify me. I consent to my child's being transported to a physician or licensed medical facility. I give permission for diagnosis, treatment, and/or care which in the best judgement of the physician or dentist, may be required. This permission is valid for this school year as long as the child remains in the Head Start/State program.

Consentimiento para Tratamiento Médico: *Como el padre/la madre o tutor legal del niño/a, entiendo que en caso de una emergencia médica, el personal del centro primero llamará al 911 y despues me notificara. Doy consentimiento que se transporte mi niño/a a un consultorio médico para diagnosis, tratamiento, y/o cuidado cual sea necesario según el juicio del médico o odontólogo. Éste consentimiento será válido durante el año escolar en curso o mientras el niño/a continúe en el Programa Head Start/State.*

Signature/*Firma*_____ Date/*Fecha*_____
(Parent or Guardian) *(Padre o Tutor)*

Emergency Contacts: If parents are not available, the following persons are authorized to take child(ren) from the facility, or be called in case of emergency. The child(ren) will **NOT** be able to leave with **ANY OTHER PERSON** without written authorization from the parent/guardian.

Name_____ Relationship_____

Address_____ Phone_____

Name_____ Relationship_____

Address_____ Phone_____

Name_____ Relationship_____

Address_____ Phone_____

Updates will be added to all copies of the emergency cards

Distribution: White– Health Yellow – Parent Pink – Emergency Card Binder Copy – State Eligibility File (if applicable)

Mandatory
Revised 1/16
CF/R-3