MountainHeart Community Services, Inc.
Head Start/Early Head Start Program
Consent for Emergency Medical/Dental Treatment

A: Family Information:

1. **Child's Name: _____ DOB: ____/_____/_____**
   Social Security #: _____/_____/_____ Male _____ Female _____
2. **Head Start Center: _____ Telephone: _____**
3. **Mother's Name: _____ Soc. Sec.# _____/_____/_____**
   Employer: _____
   Home Address: _____ City: _____ State: ___ Zip: _____
   Physical Address: _____
   Work Address: _____ City: _____ State: ___ Zip: _____
   Home/Cell Phone: _____ Work Phone: _____
4. **Father's Name: _____ Soc. Sec. # _____/_____/_____**
   Employer: _____
   Home Address: _____ City: _____ State: ___ Zip: _____
   Physical Address: _____
   Work Address: _____ City: _____ State: ___ Zip: _____
   Home/Cell Phone: _____ Work Phone: _____

B: Emergency Contacts:

1. **In case of an emergency and if the parents/guardian are not available, please contact:**
   Name: _____ Phone: _____
   Address: _____ City: _____ State: ____ Zip: _____
   Physical Address: _____
   Name: _____ Phone: _____
   Address: _____ City: _____ State: _____ Zip: _____
   Physical Address: _____
2. **Child's Doctor: _____ Phone: _____**
   Address: _____ City: _____ State: _____ Zip: _____
3. **Insurance Company: _____ Policy #: _____**
4. **Preferred Hospital/Clinic: _____**
5. **Allergies: _____**
6. **Health Concerns: _____**

In the event of an emergency, I understand and fully agree that Head Start will follow the approved procedures for medical emergencies.

_____ I have been provided a copy of the emergency medical procedures.

Signature: _____ Date: _____