Hoosier Uplands Head Start/Early Head Start
Emergency Medical & Transport Authorization

Participant Name:_____ Date of Birth:_____

Primary Insurance:_____ Policy #:_____

Secondary Insurance:_____ Policy #:_____

Current Physician's Name:		**Phone Number:**
Address	**City**	**State**

Current Dentist's Name:		**Phone Number:**
Address	**City**	**State**

Current Vision Provider's Name:		**Phone Number:**
Address	**City**	**State**

If my child's medical/dental provider cannot be contacted, I prefer my child be taken to the emergency department of _____ hospital.

I understand that Hoosier Uplands Head Start staff will attempt to contact the persons listed on my emergency and transportation contacts form to be with my child in my absence. I understand that it is my responsibility to inform Head Start staff about any changes that may occur in the information included in this form.

In case of an emergency (accident or illness), I request that Hoosier Uplands Head Start staff contact me. If the staff is unable to reach me, I authorize Head Start staff to contact my child's medical provider, dental provider, and/or vision provider and make whatever arrangements they deem necessary to care for my child, including transportation decisions. This authorization does not cover a surgical procedure unless the medical opinions of two licensed physicians or dentists are obtained prior to performance of surgery.

Parent/Guardian Signature:_____ Date:_____

Completed at first home visit for HS, annually in August for EHS, and any time there is a change in the above information.
Original to Data Entry
CC: Teacher, Home Visitor & Bus Driver
Revised 2/2014 rm