

**Classroom Emergency Plan - Collaborative Students
School Year - 2024-2025**

Non-Head Start

Child's Name: _____ Child's DOB: _____ Center: _____
 Parent/Guardian Names: _____ Home Address & City: _____

I or my child's child-care provider can be reached at the following phone numbers during class times:

Home # _____ Work # _____ Child Care # _____

Yes or No

My child may be released only to the person signing this form or to the following person(s):
 (Attach additional names as needed.)

Name	Relationship to Child	Phone Number

Yes or No

I give permission for Classroom staff to secure emergency medical and dental treatment if such treatment is required. This permission is granted to the following:

	Clinic Name	Address & City	Phone
Emergency Medical:			
Emergency Dental:			

I understand that Classroom staff will make every effort to contact me in order to obtain my consent to allow for specific procedures recommended by the physician/dentist.

Classroom staff may contact the following persons if parent/guardian cannot be reached in an emergency. List two.

Name:	Address (Including City)	Phone Number

Yes or No

I give permission for my child's name/photograph to be used for center activities in the classroom or hallways including newsletters, nametags, cubbies, class or child projects, books, displays or posters.

I give permission for my child to be included in videotaping of classroom activities or for observation purposes.

I give permission for my child's name/photograph to be used on the Agency/School District website and the local newspaper.

Your Head Start Center participates in the United States Department of Agriculture (USDA) Child & Adult Care Food Program (CACFP). Head Start receives Federal cash assistance to serve healthy meals to your children. Meals served in Head Start must meet nutrition requirements established by USDA's Child & Adult Care Food Program. In order to participate, Head Start has agreed to follow the USDA guidelines

Center.	Beginning Date of Child Care:			
Enter the normal hours your child attends Head Start - For example: 8:30 AM - 12 PM or 10 am -1:30 pm	<table border="0"> <tr> <td>Hours from: _____ to _____</td> <td> 7\Y\W the days your child normally attends: <ul style="list-style-type: none"> <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday </td> <td> Check the meals your child normally receives while in care: <ul style="list-style-type: none"> <input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack </td> </tr> </table>	Hours from: _____ to _____	7\Y\W the days your child normally attends: <ul style="list-style-type: none"> <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday 	Check the meals your child normally receives while in care: <ul style="list-style-type: none"> <input type="checkbox"/> Breakfast <input type="checkbox"/> AM Snack <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack
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In accordance with Federal law and U.S. Department of Agriculture policy, WCMCA, Inc. is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability.

I have read or discussed this agreement and understand what I am signing.

Signature of Parent/Guardian _____ Date _____