Non-Head Start

## Classroom Emergency Plan – Collaborative Students
## School Year - 2023-2024

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.

| | Address (Including City) | Phone Number |
|---|---|---|
| Name: | | |
| Name: | | |

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.

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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 | Hours from: ___________ to ___________ | 7\YW the days your child normally attends | ☐ Monday<br>☐ Tuesday<br>☐ Wednesday<br>☐ Thursday<br>☐ Friday | Check the meals your child normally receives while in care | ☐ Breakfast<br>☐ AM Snack<br>☐ Lunch<br>☐ PM Snack |

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**__________________

FES keep copy with your Head Start Emergency Agreements