WCMCA Head Start Substitute/Volunteer Emergency Agreement

Name: _____ **Center/Area:** _____

Address: _____

Phone: _____ **Date of Birth:** _____

Cell Phone: _____

Email Address: _____

I agree that (Circle One):

Yes No Head Start staff may secure emergency medical and dental treatment if such treatment is required. This permission is granted to the following:

Dental: _____ Phone: _____

Address: _____

Medical: _____ Phone: _____

Address: _____

Medical Conditions: _____

Allergies: Yes No (Circle One) Describe Condition_____

Head Start may contact the following persons in an emergency (List at least two):

Name	Address	Phone	Relationship

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

Signature: _____

Date: _____

FES - Keep with your Children's EEA's in emergency binder