WCMCA Head Start
Emergency Agreement
2026-2027

IDENTIFYING INFORMATION Please include parent/guardians **that live with the child.** If a parent/guardian does not live with the child, he/she can be listed as an emergency contact below.		
Child's Name:	Birthdate:	Head Start FES:
Home Address:	City:	Zip:
Parent/Guardian Name 1:	Primary Phone #:	Opt in for Text Messages Yes No
Email Address:	Additional Phone #:	Opt in for Text Messages Yes No
Parent/Guardian Name 2:	Primary Phone #:	Opt in for Text Messages Yes No
Email Address:	Additional Phone #:	Opt in for Text Messages Yes No
EMERGENCY CONTACTS The parent/guardian will be the first person we attempt to contact. In case the parent/guardian cannot be reached, you must supply at least 2 Emergency Contacts **other than** the parent/guardian(s) that lives with the child. Please include all the information requested. The persons listed below must show proper identification before the above-named child will be released from the center.		
Name:	Relationship to your child:	Phone Number:
City:		Authorized to Pick Up Child? Yes No
Name:	Relationship to your child:	Phone Number:
City:		Authorized to Pick Up Child? Yes No
Bus Company (if applicable):	Drop-off	Pick-up Both

RESTRICTIONS: See Custody Disputes/Unauthorized Access to Child Policy for questions.

☐ Yes*	☐ No	Is there an Order for Protection or Restraining Order in place involving ***this child***? *If YES, you must provide WCMCA Head Start with a copy.
Child May **NOT** be released to: Name: _____ Relationship to your child: _____		
☐ Yes*	☐ No	Are there legal restrictions to releasing the child during Head Start hours to their other parent? *If YES, you must provide WCMCA Head Start with a copy of the order.

MEDICAL AND INSURANCE INFORMATION Please provide the following information in the event that emergency services are needed for your child.

Medical Coverage: Medical Assistance/MN Care Private Other ID# None	
Dental Coverage: Medical Assistance/MN Care Private Other ID# None	
Medical Clinic:	Dental Clinic:

☐ Yes	☐ No	If I cannot be reached in an emergency, I give permission to Head Start staff to take all emergency measures deemed necessary for the care of my child and I understand Head Start is not responsible for costs not covered by my insurance.

Signature of Parent/Guardian: **Date:**

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PERMISSIONS & AGREEMENTS		
☐ Yes	☐ No	I give permission for Head Start to exchange info with _____ County Public Health and WIC program.
☐ Yes	☐ No	I give permission for Head Start to exchange relevant developmental info with _____ School District.
☐ Yes	☐ No	I give permission for Head Start to use photos/videos of my child and family for classroom, hallways, public relations, and program outreach. (Cross out any use you don't approve of and initial here: _____.)
☐ Yes	☐ No	I give permission for health professionals to determine my child's medical and oral health status of care.
☐ Yes	☐ No	I agree to submit a physical exam for my child (including hearing, vision, development, social/emotional screening, a lead and a hemoglobin test) within 30 days of enrollment and to complete any recommended treatment.
☐ Yes	☐ No	I agree to complete a dental exam for my child within 90 days of enrollment and to complete any recommended treatment.
☐ Yes	☐ No	I agree to follow the MN Child & Teen Check-up schedule of Age-Related Screening and Immunization Standards for my child.
☐ Yes	☐ No	I will plan and participate in the required number of home visits/parent conferences and family events. My child will attend center days on a regular basis. If I or my child are unable to attend, I will notify staff prior to the scheduled start time.
☐ Yes	☐ No	Head Start staff and cooperating partners have permission to diaper my child, including the use of wipes and over-the-counter creams as needed.
☐ Yes	☐ No	I give permission for sunscreen lotions, hand cream, or insect repellant to be administered according to the manufacturer's instruction or instruction from the family's licensed physician or dentist.

Signature of Parent/Guardian: **Date:**