HAMILTON MADISON HOUSE

Emergency Treatment and Consent Form

Is anyone legally restricted from being in contact with your child? ☐ Yes ☐ No **If yes, name of person(s):**

(Staff: request a copy of legal documentation)

	Child's Name:
	Date of Birth:
	Center/Site Name:
	Child's Home Address (House/Apt #, Street, City, Zip):

	Parent/Guardian 1	**Parent/Guardian 2**
Name:		
Relationship to Child:		
Primary Language(s):	☐English ☐ Spanish ☐ Chinese ☐ Other	☐English ☐ Spanish ☐ Chinese ☐ Other
Does Child lives with you:	☐ Yes ☐ No, if no list mailing address:	☐ Yes ☐ No, if no list mailing address:
Phone Number:	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work
Alternate Phone Number:	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work
Email Address:		
When is the best time to reach you?	☐ Mornings ☐ Afternoons ☐ Evenings ☐ Anytime	☐ Mornings ☐ Afternoons ☐ Evenings ☐ Anytime
What is the best way for us to communicate with you?	☐ Note in child's backpack ☐ Phone call ☐ Text ☐ Email ☐ Face-to-face	☐ Note in child's backpack ☐ Phone call ☐ Text ☐ Email ☐ Face-to-face

Authorized to be released to/to pick up – People listed below must show proper identification before your child will be released from the center. No child will be released to a person under the age of 18. **I give permission for my child to be released to the following people for the current program year.**

Name	**Relationship to Child**	**Phone Number**

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Name of Emergency Contact:	Relationship to Child:
City and State:	Phone: ☐ Cell ☐ Home ☐ Work

Child's Health Care Provider:	Phone: ☐ Cell ☐ Home ☐ Work
Medical Conditions/Allergies, if any:	Medications:
Child's Insurance: ☐Medicaid ☐Private Insurance ☐Child Health Plus ☐Other	Insurance ID #:

Child's Dentist:	Phone: ☐ Cell ☐ Home ☐ Work

Child's Child Care Provider, if applicable:	
Address (Building/House #, Street, City, Zip):	Phone: ☐ Cell ☐ Home ☐ Work

If initialed, this means I give consent for the following while my child is enrolled in Hamilton-Madison House Early Child Services.

Consent for Services

____ Activities and Transportation

____ Developmental screenings

____ Health screenings (check eyes, hearing, height, and weight)

____ Dental screenings (check teeth and gums)

____ Use of fluoridated toothpaste

____ Access to and retention of immunization record

____ Photograph/video as part of classroom activities and display

____ Photograph/video to build partnerships with community agencies

____ Mental Health screenings

For your child's safety, your signature below grants trained program staff permission to provide your child with emergency treatment including First Aid and CPR. When deemed immediately necessary, medical, surgical and hospital care, treatment, and procedures will be provided by your child's regular health care provider, or by a licensed physician or hospital, if your regular health care provider cannot be reached. If you cannot be reached, transportation will be provided by ambulance, or by any of the people named above to an emergency center for treatment.

Parent/Guardian Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Consent for Services
我同意

While my child當我的小孩 , _____is participating in the Hamilton Madison House Early Childhood Services. 在參加麥迪巨托兒中心服務期間.

☐ Yes ☐ No That my child may be transported as necessary to services, to and from the Center, for educational field trips, neighborhood walks and/or in the event of emergency. 小孩參與外戶活動, 教育上的外出, 鄰近步行及緊急訓練活動.

☐ Yes ☐ No That in case of an emergency, if parent/guardian cannot be contacted, qualified HMH personnel may provide first-aid or obtain emergency medical care if it is needed. 小孩在緊急情況時刻, 如果家長/監護人聯繫不到, 職員可以提供急救處理行動.

☐ Yes ☐ No That my child may receive all necessary health and developmental screenings, assessments required by the program.
小孩接受所有要求的健康和成長發育上的程式評估.

☐ Yes ☐ No I understand that Mental Health professionals will be making routine Mental Health observations at the HMH Early Childhood Services. I hereby give my permission for the Mental Health professionals to review my child's records and to advice on behavior concerns. 我的小孩接受心理健康專業人員將進行常規的心理健康觀察, 我特此准許心理健康專家查看我的孩子紀錄, 並建議有相關行為的問題.

☐ Yes ☐ No That my child may receive a dental, vision, hearing screening and other community partnerships that HMH may have, you will receive information on results and needed follow-up. 小孩接受牙科, 視力, 聽力考查和麥迪巨社區合作夥伴的服務, 您將收到有關測試的結果, 有必要時,需要家長/監護人跟進.

☐ Yes ☐ No That this is my authorization for my child's Developmental Screening, Assessment and Summary of Services to be transferred to the public school, if requested by either parent / school.
麥迪巨托兒中心,在任何一方:家長或公立學校的要求下,可將我孩子的評估及總結服務可轉移向公立學校.

☐ Yes ☐ No That my child's picture and/or video may be used for promotional, educational or school publication purposes, including social media. 小孩的照片和/或影像可用於在宣傳, 教育或學校出版, 包括社會媒體.

ALL CHILDREN'S RECORDS ARE KEPT IN STRICT CONFIDENCE. RECORDS WILL BE REVIEWED ONLY BY HMH STAFF, HEALTH AND MENTAL HEALTH SERVICE PROVIDERS AND MULTIDISCIPLINARY TEAM MEMBERS, UNLESS OTHERWISE INSTRUCTED IN WRITING BY THE PARENT. STATISTICAL DATA WILL BE USED FOR ANNUAL PROGRAM INFORMATION REPORTS.

小孩所有的記錄都嚴格保密。只有麥迪巨工作人員、心理健康專業人員, 服務提供者才能查看記錄.
除非父母另有書面指示。資料將用於年度計畫資訊報告.

I have read and understand the above statements. I give my consent for those services checked "Yes".

我已經理解上述所說的並同意我孩子接受有打鉤 "是" 的服務.

Parent/Guardian Signature: **Date:**

Staff Signature: **Date:**