Mid-Bronx CCRP Early Childhood Center Inc.
1125 Grand Concourse
Bronx, New York 10452
Telephone: (718) 590-7014 Fax: (718) 590-7059
midbronxccrp.org

Activity/Park Permission Slip

Child's Name _____Date of Birth_____

I hereby grant permission for my child to use all of the play equipment and participate in all of the activities of the school.

I hereby grant permission for my child to leave the school premises under the supervision of a staff member for neighborhood walks or field trips in an authorized vehicle.

I hereby grant permission for the Director or Acting Director to take whatever steps may be necessary to obtain emergency medical care if warranted. These steps may include, but are not limited to, the following:

1) Attempt to contact a parent or guardian.
2) Attempt to contact the child's physician.
3) Attempt to contact you through any of the persons listed on the emergency information form you completed for us.
4) If we cannot contact you or your child's physician we will do any or all the following:
   (a) Call another physician or paramedics, (**b**) call an ambulance, (**c**) have the child taken to an emergency hospital in a company of a staff member.
5) Any expenses incurred under #4, above will be borne by the child's family.
6) The school will not be responsible for anything that might happen as a result of false information given at the time of enrollment.
7) The school will not assume responsibility for a child until **he/she** has been received by the teacher at **his/her** designated class time.

Signed_____ (Mother/Guardian) Date _____
Signed_____ (Father/Guardian) Date _____
Home Telephone # _____ Emergency # _____
Emergency Contact Name _____
Hospital or Doctor_____
Telephone # _____ Address _____
Child's Medicaid information: ID # _____
Allergies: _____
Special Health/feeding conditions _____

This consent is valid for one year after the date signed.

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CONSENT FOR CHILD'S EMERGENCY MEDICAL/DENTAL TREATMENT

I, _____, hereby give my consent for emergency medical or
(Print Parent/Guardian Name)
dental treatment of the child or children listed below by any licensed physician or dentist while under the care of **Mid-Bronx CCRP Early Childhood Center Inc.** (Child Care Provider) and for transport of the child to and from the source of emergency treatment.

This care may include examinations and any tests which, in the opinion of the physician or dentist, are deemed necessary or advisable.

This does not include the right to perform surgical operations without my further consent, except in the case of an emergency and when after an effort has been made to locate me, I am found to be unavailable.

This consent is valid for one year after the date signed.

The purpose of this consent form has been explained to me.

Child's Name _____ **Child's D.O.B.** _____

Signature: _____

Relationship: _____

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I have explained to _____ the purpose of this consent form.
(Name of parent/guardian)

Signature of Head Start Staff: _____ Date _____