

THE FALLS CHURCH EPISCOPAL DAY SCHOOL
Permission for Emergency Care 2023-2024

Name of Student: _____ Birth Date: _____
Last First Month/Day/Year

Name of Parents/Guardian: _____
Last First

Address of Student: _____

Home Phone: _____ Cell Number – Mom: _____

Cell Number -- Dad: _____

Primary language spoken at home: _____ Work Phone - Mom: _____

Work Phone – Dad: _____

Emergency Contact Other than Parent(s): _____ Phone: _____
(Please list a local person)

Student's Insurance: _____
Company Name

Policy Number

Group Number

Student's Physician: _____ **Phone:** _____

Is the student allergic to any medication? Yes No If yes, please list _____

Does the student have any other allergies? Yes No If yes, please list _____

Is the student under a physician's care for health needs on a continuing basis? Yes No

If yes, please describe: _____

Is the student under medication or treatment on a continuing basis? Yes No

If yes, please describe: _____

A school staff member will communicate with parents to provide any necessary school assistance.

The school has my permission, in an emergency when I cannot be contacted, to take my child to the emergency room of the nearest hospital, or to call the rescue squad which may then take my child to the nearest hospital; the rescue squad, the hospital, and its medical staff have my authorization to provide treatment which a physician deems necessary for the well-being of my child.

Parent/Guardian Signature

Date

The original of this shall be readily accessible in the school office and taken to the hospital with the patient.