THE FALLS CHURCH EPISCOPAL DAY SCHOOL

Permission for Emergency Care 2022-2023

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:____

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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.