

DIOCESE OF ARLINGTON PERMISSION FOR EMERGENCY CARE

To be completed by parent/guardian at beginning of school year

NAME OF STUDENT _____ Grade _____ Room # _____
(nickname)

Address _____
(Street) (City) (Zip)

Student's Date of Birth _____ Male Female Home Phone _____

Father's Name _____ Work Phone _____ Hours _____

Father's Email Address _____ Cell/Pager _____

Mother's Name _____ Work Phone _____ Hours _____

Mother's Email Address _____ Cell/Pager _____

Father's Address (if different) _____

Mother's Address (if different) _____

Father's Workplace & Address _____

Mother's Workplace & Address _____

Name(s) of Person(s) or Agency Having Legal Custody* _____

Address _____

Persons NOT Authorized to pick up child from school*

Name _____ Relationship _____

Child's Doctor _____ Phone Number _____

Outstanding Medical History (e.g. diabetes, heart disease, contact lenses, hearing aids, etc.)

Child's Allergies (if any) _____ Action to Take _____

Medications Child is Taking _____ Date of Last Tetanus Shot _____

Insurance Company _____ Policy Number _____

Emergency Contacts: In the event a parent cannot be reached, **you must** give the name, address, and phone number of two persons who could pick up and take your child home in a timely manner.

1) _____
(Name) (Address) (Relationship) (Phone)

2) _____
(Name) (Address) (Relationship) (Phone)

I agree to pick up my sick or injured child in a timely manner when contacted. If I cannot be reached, the above emergency contacts can be called to pick up my child. Additionally, if I cannot be contacted in an emergency, the school has my permission to take my child to the emergency room of the nearest hospital and I hereby authorize its medical staff to provide treatment, which a physician deems necessary for the well-being of my child.

(Signature of Parent/Guardian) (Date)

*Appropriate custody paperwork must be attached.