



CITY OF FALLS CHURCH

Permission for Emergency Care

Name of Student _____ Birthday _____

Name of Parent/Guardian _____

Address: _____

Home Phone _____ Business Phone(s) _____ Cell Phones _____

Local Emergency Contact _____ Phone _____

Parent/Guardian Insurance – Company Name _____

Parent/Guardian Insurance – Policy Number _____

Student’s Physician _____ Phone _____

Is the student allergic to any medication? Yes ___ No ___ If so, specify type. _____

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

If so, describe. _____

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

Is so, 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.

Falls Church Community Center • 223 Little Falls Street • Falls Church, Virginia 22046

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