



# CITY OF FALLS CHURCH

## Permission for Emergency Care

Name of Student \_\_\_\_\_ Birthday \_\_\_\_\_  
(Last) (First)

Name of Parent/Guardian \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone(s) \_\_\_\_\_ Cell Phones/Pagers \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
(Please list *local* name and phone number)

Parent/Guardian Insurance \_\_\_\_\_  
(Company Name)

\_\_\_\_\_  
(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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