Permission for Emergency Care/Medical Information
Extended Day Program 2009-2010

Name of Student ____ Grade _________________________

Teacher/Class __________________Address ____

Father/Guardian's Name ____

Work Phone (   ) ____________________Cell Phone (   ) ____________________

Address ____ Home Phone (   ) _______________

Mother/Guardian's Name ____

Work Phone (   ) ____________________Cell Phone (   ) _____________________

Address ____ Home Phone (   ) ________________

Physician's Name _______________________________________ Physician's Phone (   ) ______________

Child's Food Allergies ____

Child's Allergies to Medicine ____

Child's Outstanding Medical History (Ex. Diabetes, heart disease, contact lenses, hearing aids, etc.)
____

Medications Child is Taking ___________________________________ Date of last Tetanus Shot _______

Insurance Company ____ Policy Number ____________

Persons **NOT** authorized to pick up child from school____
(Please attach appropriate paperwork)

Emergency Contacts: *(To be called to pick up the child if parent/guardian cannot be reached. Please list two)*

1. Name ____ Driver's License #. or SSN ___________________

Address ____

Relation to Child _______________ Home Phone (   ) ______________ Work Phone (   ) ______________

2. Name ____ Driver's License #. or SSN ___________________

Address ____

Relation to Child _______________ Home Phone (   ) ______________ Work 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/Extended Day Program, 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