

# DIOCESE OF ARLINGTON PERMISSION FOR EMERGENCY CARE

To be completed by parent/guardian at beginning of school year. (Type information and print out.)

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ Room # \_\_\_\_\_  
Nickname \_\_\_\_\_

Address \_\_\_\_\_  
(Street) \_\_\_\_\_ (City) \_\_\_\_\_ (Zip) \_\_\_\_\_

Home Phone \_\_\_\_\_ Home Email Address \_\_\_\_\_

Student's Date of Birth \_\_\_\_\_  Male  Female

Father's Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Father's Email Address \_\_\_\_\_ Cell/Pager \_\_\_\_\_

Father's Address (if different) \_\_\_\_\_

Father's Workplace & Address \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother's Email Address \_\_\_\_\_ Cell/Pager \_\_\_\_\_

Mother's Address (if different) \_\_\_\_\_

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 \_\_\_\_\_

Student's Doctor _____	Phone # _____
Outstanding Medical History (e.g. diabetes, heart disease, contact lenses, hearing aid, etc.) _____	
Student's Allergies (if any) _____	Action to take _____
Medications Student is taking _____	Date of Last Tetanus Shot _____
Insurance Company _____	Policy # _____

**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 student home in a timely manner.

1) \_\_\_\_\_  
Name \_\_\_\_\_ Address \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

2) \_\_\_\_\_  
Name \_\_\_\_\_ Address \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

I agree to notify the school within 24 hours if my child or any member of my immediate household has developed a communicable disease. I agree to notify the school immediately if the disease is life threatening. 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, when a physician deems necessary for the well-being of my child.

\_\_\_\_\_  
Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

\*Appropriate custody paperwork must be attached.