

Permission for Emergency Care Appendix F-1

To be completed and signed annually by a parent/guardian

Citroet City (State) (Zip)	Legal Name: Last		First		Middle	
Home Phone Email for official school communication Name(s) of any sibling(s) at school	Nickname		Sex _ Male _ F	emale l	Date of Birth (mm/dd/yyy	y)//
Home Phone Email for official school communication Name(s) of any sibling(s) at school Student lives with (applicable custody paperwork must be attached): Mother/Female Guardian Full Name Maiden Name Home Address Home City/State/Zip Home Phone Home Email Cell Phone Work Phone Work Phone Work Phone Work Phone More City/State/Zip Home John Semall Work Address Cocupation Employer Married Separated Divorced* Widowed Single Remarried *Appropriate custody paperwork MUST be attached. Persons NOT authorized to pick up the student from school: Name Emergency Contacts: In the event a parent/guardian cannot be reached, you must give the name, address and phone number of two persons who could collect the student from school in a timely manner. 1) (Name) (Address, City, State, Zip) (Phone) (Relationship) Student's Doctor Outstanding Medical History (e.g. diabetes, heart disease, contact lenses, hearing aid, etc.) Allergies Student's Medications Insurance Company • agree to notify the school within 24 hours if my child or any member of their immediate household has developed a communicabilor 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 to their contracted. If I cannot be reached, the above emergency contacts can be called to pick up my child not any promise of their immediate household has developed a communicabile 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 to their contracted. If I cannot be reached, the above emergency contacts can be called to pick up my child Address of the solution of the nearest hospital and I hereby authorize its medical staff to provide treatment, when or physician deems necessary for the well-being of my child. - I certify that the information provided in this document is true and accurate to the best of my knowledge.	Home Address					
Name(s) of any sibling(s) at school Student lives with (applicable custody paperwork must be attached): Mother/Female Guardian Full Name Maiden Name Maiden Name Home Address Home City/State/Zip Home Phone Home Email Cell Phone Work Email Work Address Occupation Employer Married Separated Divorced* Widowed Single Remarried "Appropriate custody paperwork MUST be attached." Persons NOT authorized to pick up the student from school: Name Relationship Emergency Contacts: In the event a parent/guardian cannot be reached, you must give the name, address and phone number of two persons who could collect the student from school in a timely manner. 1) (Name) (Address, City, State, Zip) (Phone) (Relationship) Student's Doctor Quistanding Medical History (Address, City, State, Zip) (Phone) (Relationship) Student's Doctor Quistanding Medical History (a.g. dilabetes, heart disease, contact lenses, hearing aid, etc.) Allergies Student's Medications Insurance Company Policy # I agree to notify the school within 24 hours if my child or any member of their immediate household has developed a communicable disease. I agree to notify the school inmediately if the disease is life thereatening, I agree to pick up my sick or injured child in a timely manner when contacted. If I cannot be reached, he above emergency contacts can be called to pick up my sick or injured child in a timely manner. 1 agree to notify the school within 24 hours if my child or any member of their immediate household has developed a communicable disease. I agree to notify the school immediately if the disease is life thereatening, 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 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 in terminate to the best of my k			•	• /	, ,	
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Student's Doctor	2)(Name)	(Addres	s. Citv. State. Zip)		(Phone)	(Relationship)
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 I agree to notify the school within 24 hours if my child or any member of their 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. I certify that the information provided in this document is true and accurate to the best of my knowledge. 						
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