Diocese of Arlington Catholic Schools
Office of Catholic Schools

Permission for Emergency Care

Appendix F-1

To be completed and signed annually by a parent/guardian

Legal Name: Last _____ First _____ Middle _____

Nickname _____ Sex ☐ Male ☐ Female Date of Birth (mm/dd/yyyy) ___/___/____

Home Address _____
(Street) (City) (State) (Zip)

Home Phone ___-___-____ Email for official school communication _____

Name(s) of any sibling(s) at school _____ Grade(s)/Room _____

Student lives with (*applicable custody paperwork must be attached*): _____

	Mother/Female Guardian	**Father/Male Guardian**
Full Name		
Maiden Name		
Home Address		
Home City/State/Zip		
Home Phone		
Home Email		
Cell Phone		
Work Phone		
Work Email		
Work Address		
Occupation		
Employer		
Marital Status (Circle)	Married Separated Divorced* Widowed Single Remarried	Married Separated Divorced* Widowed Single Remarried

Appropriate custody paperwork MUST be attached.

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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)

2) _____
(Name) (Address, City, State, Zip) (Phone) (Relationship)

Student's Doctor _____ Phone# _____

Outstanding Medical History _____
(e.g. diabetes, heart disease, contact lenses, hearing aid, etc.)

Allergies _____ Action to Take _____

Student's Medications _____ Date of Last Tetanus Shot _____

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 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.

_____ _____ __/__/____
Printed Name of Parent/Guardian Signature of Parent/Guardian Date

Revised 2016