

Fairfax Presbyterian Preschool AUTHORIZATION FOR EMERGENCY TREATMENT

I, _____, hereby authorize any physician member of the
(Print Parent/Guardian Name)

Department of Emergency Medicine of Fairfax Hospital, Fair Oaks Hospital, Access of Fairfax, Access of Reston/Herndon, Mount Vernon Hospital, Jefferson Hospital and/or any member of the Medical Staffs of the above mentioned hospitals requested by the Department of Emergency Medicine physician, to render medical treatment which in his judgment maybe deemed necessary

in the care of: _____
(Print Child/Dependent Name)

Family Contact Information

Child's Birth Date: _____ Home Phone: _____

Mother (or Guardian #1)
Name: _____ Cell Phone: _____

Language Spoken: _____ Business Phone: _____

Home Phone if Different from
Child's: _____

Father (or Guardian #2)
Name _____ Cell Phone : _____

Language Spoken: _____ Business Phone: _____

Home Phone if Different from
Child's: _____

Emergency Contacts (Other Than Parents/Guardians)

Contact 1 Name: _____ Primary Phone: _____

Language Spoken: _____ Secondary Phone: _____

Address: _____

Contact 2 Name: _____ Primary Phone: _____

Language Spoken: _____ Secondary Phone: _____

Address: _____

Physician and Dental Information

Child's Doctor/Medical Care
Provider: _____ Phone: _____

Child's Dental Care Provider: _____ Phone: _____

***** PLEASE FILL OUT OTHER SIDE *****

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Current Health Conditions

Below check any current health conditions that may require attention during the school day. Also complete and submit the *Commonwealth of Virginia School Entrance Form (MCH-213 E)*.

Allergies (be specific)

foods: _____

medicines: _____

bee stings or insect bites: _____

other: _____

Asthma

Cancer

Diabetes

Hearing Problems

Heart Problems (be specific): _____

Hemophilia

Seizures

Hearing aid(s)

Physical Disability (be specific): _____

Respiratory (be specific): _____

Vision problems (be specific): _____

Glasses

Contacts

Other (be specific): _____

List all medications and dosage your child receives on a continual basis:

In case of sickness or injury to my child, I will not hold Fairfax Presbyterian Preschool, its Director or its Staff responsible. If my child should become ill while at school, I understand that I will be contacted. I or someone I designate will immediately pick my child up from school. If my child should meet with an accident or become ill while in school and I cannot be reached immediately, I authorize the Director, Assistant or Teacher to secure medical aid for my child.

Parent/Guardian Signature: _____

Date: _____

*** PLEASE FILL OUT OTHER SIDE ***