St. Albans Country Day School

EMERGENCY INFORMATION ~ 2020-2021 School Year

NAME_____ **BIRTHDATE**_____ **GRADE**_____
Last First Middle

ADDRESS_____ **Phone**_____
Number Street City Zip Code

☐ **PLEASE CHECK BOX IF YOU HAVE A NEW ADDRESS FROM LAST SCHOOL YEAR**

ADDRESS_____ **Phone**_____
Number Street City Zip Code

☐ **PLEASE CHECK BOX IF YOU HAVE TWO ADDRESSES FOR MAILINGS**

Prefix: Mr., Mrs., Ms., Miss, Dr., The Honorable, etc:_____
Father_____ Home Phone_____Cell Phone_____
Employer_____ Occupation_____ Work Phone_____
Mother_____ Home Phone_____Cell Phone_____
Employer_____ Occupation_____ Work Phone_____

If my child is ill or has an emergency and I cannot be reached, please call and release my child to:

NAME_____ **Phone**_____ **Cell Phone**_____
Circle one: Babysitter Friend Relative

Physician's Name_____ **Med.Ins.Co.**_____**ID#**_____
Address_____ **Phone**_____

Circle one **1.** In the event of an emergency, when a parent or guardian is unavailable, I authorize school personnel to make arrangements for my child to receive medical/hospital care, including necessary transportation, in accordance with their best judgment. If said physician is unavailable, I authorize that such care and treatment be performed by a licensed physician or surgeon. I agree to pay all costs incurred as a result of the foregoing.

2. I do not choose the above statement and desire the following action in the event of an emergency:
_____
_____

X_____ _____ **X**_____ _____
Parent/Guardian Signature **Date** **Parent/Guardian Signature** **Date**

I authorize St. Albans Country Day School to release my child to the following individuals:

_____ _____ _____
(Name) (Relationship) (Phone)

_____ _____ _____
(Name) (Relationship) (Phone)

***Please indicate e-mail addresses where you would like to receive *Tuesday News* & school contact:**

1._____ **2.**_____

☐ **PLEASE CHECK HERE IF THERE ARE KNOWN HEALTH PROBLEMS AND FILL OUT ALLERGY ACTION PLAN SHEET.**

PLEASE DESCRIBE ANY MEDICAL PROBLEM OR ALLERGY WHICH COULD REQUIRE SPECIAL CARE OR MEDICATION AT SCHOOL (ie. glasses, hearing problem, headaches, asthma, etc.)**:**

_____
_____

☐ **PLEASE CHECK HERE IF SCHOOL CAN ADMINISTER TYLENOL AND/OR MOTRIN TO YOUR CHILD**
☐ **PLEASE CHECK HERE IF SCHOOL CAN ADMINISTER CHILDREN ZYRTEC AND/OR BENEDRYL TO YOUR CHILD**