Augusta School
46839 Maple Leaf Place Sterling Virginia 20164 571-434-6200

EMERGENCY INFORMATION FORM

Instructions to Parents/Guardians

(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY

Child's Name: _____ Date: _____

Enrollment Date: _____ Hours & Days of Expected Attendance: _____

Child's Home Address: _____

Mother's Name: _____Drivers License #:_____

Mother's Home Address (*if different from above*):_____

Mother's Employer / School: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Father's Name: _____ Drivers License #: _____

Father's Employer / School: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Name of Persons Authorized to Pick Up Child Daily if Different then Parents:

Name: _____Drivers License #: _____

Address: _____ Phone Number: _____

Name: _____Drivers License #: _____

Address: _____ Phone Number: _____

When parents cannot be reached, list at least two people who may be contacted to pick up the child in an emergency:

1. Name: _____ Home Phone: _____ Cell Phone: _____
   Address: _____
2. Name: _____ Home Phone: _____ Cell Phone: _____
   Address: _____
3. Name: _____ Home Phone: _____ Cell Phone: _____
   Address: _____

Child's Physician or Source of Health Care: _____ Phone Number: _____
Address: _____

Child's Dentist or Source of Dental Care: _____ Phone Number: _____
Address: _____

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at Augusta School to have your child transported to that Hospital.

_____ _____
Signature of Parent / Guardian Date

ANNUAL UPDATES: _____ _____ _____ _____
Initials / Date Initials / Date Initials / Date Initials / Date

Last Date of Enrollment (For School Purposes only): _____

Instructions to Parent:

1. Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
2. If necessary, have your child's health physician review the information you provide below and sign and date where indicated.

Child's Name: _____ Date: _____

Medical Condition(s): _____

_____

Medications currently being taken by your child: _____

_____

Date of your child's last tetanus shot: _____

Allergies / Reactions: _____

_____

EMERGENCY MEDICAL INSTRUCTIONS:

Signs / Symptoms to look for: _____

_____

If Signs / Symptoms appear do this: _____

_____

To prevent incidents: _____

_____

OTHER MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

_____

_____

COMMENTS: _____

_____

_____

NOTE TO PHYSICIAN:
If you have reviewed the above information, please complete the following:

_____ _____
Name of Health Physician Date

_____ _____
Signature of Health Physician Telephone Number