



EMERGENCY FORM 2021-2022

Grades K-8

Student Last Name _____

(Please print legibly)

Mother's Name _____ Home Phone _____

Mother's Address _____ Cell Phone _____

City, State, Zip _____ Work Phone _____

Occupation _____ Email _____

Company Name _____

Father's Name _____ Home Phone _____

Father's Address _____ Cell Phone _____

City, State, Zip _____ Work Phone _____

Occupation _____ Email _____

Company Name _____

Please do not publish the above information in the school directory.

Names of Children:

1. Child's Name _____ Birthdate _____ Grade _____

Health Concerns _____

(allergies, medications, prostheses, contact lenses, etc.)

2. Child's Name _____ Birthdate _____ Grade _____

Health Concerns _____

(allergies, medications, prostheses, contact lenses, etc.)

3. Child's Name _____ Birthdate _____ Grade _____

Health Concerns _____

(allergies, medications, prostheses, contact lenses, etc.)

4. Child's Name _____ Birthdate _____ Grade _____

Health Concerns _____

(allergies, medications, prostheses, contact lenses, etc.)

EXTENDED CARE

YES NO My student(s) will be using the Before/After School Extended Day Program.

(OVER)

In the event of an emergency, school closure, illness, etc., my child(ren) may be released to the following. Please include all carpool drivers, neighbors, and other family members, as needed.

Name _____	Home Phone _____
Relationship _____	Cell Phone _____
	Work Phone _____
Name _____	Home Phone _____
Relationship _____	Cell Phone _____
	Work Phone _____
Name _____	Home Phone _____
Relationship _____	Cell Phone _____
	Work Phone _____
Name _____	Home Phone _____
Relationship _____	Cell Phone _____
	Work Phone _____

our child(ren) will not be released to anyone other than those on this list. VCSA School staff will remain with him/her until they are released as requested above. The school will provide updated local media announcements regarding school closures when possible and as frequently as possible. I understand it is the responsibility of my child(ren) to notify me upon arrival at their emergency destination.

MEDICAL CARE for our family is provided by:

Doctor's Name _____ Phone _____
Clinic/Address _____

MEDICATIONS, whether over-the-counter or prescriptions, can only be dispensed at school according to the requirements stated in the Parent-Student Handbook. Prescription labels and doctor forms are required, even for over the counter medications.

MEDICAL AUTHORIZATION

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid care attendant to safeguard my child's health. I waive my right of informed consent to such treatment. I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent Signature _____ Date _____