STUDENT INFORMATION

PERMISSION FOR EMERGENCY CARE

Name ____ DOB: __________ SSN: _________________
Last First Middle
Address ____
Street (apt #, if applicable) City zip

Ethnic origin: __African American __Caucasian __Asian __Latino __Native American __ Other

If this student is enrolled in a tracking program such as Project Lifesaver, list the agency name and identifying numbers such a client and transmitter #s:
____

circle your school division: Hampton Newport News York Poquoson Gloucester Williamsburg/James City County

Parent/Guardian information Student lives with _________________________________

Mother's name __________________________ Address (if different from child) _________________________________
street (apt #, if applicable) City zip
Home# _______________ Work# _______________ Cell# _________________ Email address ___________________________

Father's name __________________________ Address (if different from child) _________________________________
street (apt #, if applicable) City zip
Home# _______________ Work# _______________ Cell# _________________ Email address ___________________________

If parents/guardians are not available, in case of emergency, accident or illness, call: ***please keep numbers updated***

Name _______________________________ Address ____
Street (apt #, if applicable) City zip
Home# _____________ Work# _____________ Cell# _______________

Name _______________________________ Address ____
Street (apt #, if applicable) City zip
Home# _____________ Work# _____________ Cell# _______________

Please specify and provide the school with proper legal documentation if a particular person does not have the authority to pick up or otherwise have contact with your child.

Is your child covered by health insurance? __ Yes __ No Name and policy # of insurance ______________________________
If my child is not currently covered under a group accident insurance plan, I understand that this can be purchased at minimal cost through his/her home school.

NEW HORIZONS PERMISSION FOR EMERGENCY CARE -continued

New Horizons has my permission to contact my family physician or another physician in an emergency when family physician or I cannot be contacted.

Doctor's name ____ Phone# ____________________

Additional doctors ____ Phone# ____________________

Dentist's name ____ Phone# ____________________

Is the student under a doctor's care for health needs on a continuing basis? __ No __ Yes (please explain)

____

Is the student taking any medications or treatments on a continuing basis? __ No __ Yes (please list)

____

Is the student allergic to any mediation? __ No __Yes (please specify) ______________________________________

Does the student have any other allergies: (please specify) ____

If the student has been diagnosed with Seizures, Asthma, Diabetes, or Allergies, a School Individualized Health Care Plan must be completed by your child's doctor.

The school has my permission, in an emergency when I (or my physician) cannot be contacted, to contact EMS to take my child to the emergency room of the nearest hospital. Further, the hospital and its medical staff have my authorization to provide treatment which a physician deems necessary for the well being of my child.
I accept full responsibility for the cost of treatment for any injury which he/she may incur while attending New Horizons.

Note: By law, a parent cannot consent in advance to any and all manner of emergency care. It is understandable that in cases, other than the need for emergency treatment, the attending physician may defer treatment pending the parent's express permission to administer specific professional service.

It is essential that the parent/guardian keep New Horizons informed when any of the information on this form changes.

The original of this form shall be readily accessible in the school office. A copy of this form will be kept in the clinic and will be taken to the hospital, if needed.

____________________________	____________________________	______________
Signature of Parent/Guardian	Name of Student	Date