Alexandria Academy
of Fine Arts & Science

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT 2014 – 2015

Student: Nickname:	Gender:	DOB: Grade Level 2014-2015:

Parent/Guardian 1:	Home Address:	Parent/Guardian 2:	Home Address:

Insurance carrier: _____ Policy #:_____

ID #: _____ Name of insured: _____

Physician: _____ Phone number: _____

Dentist: _____ Phone number: _____

Emergency contact numbers: Home Phone:_____

Parent/Guardian 1 Work: _____

Parent/Guardian 2 Work: _____

ALLERGIES (if applicapble):

Food: _____

Drug: _____ Environmental: _____

Medical Condition: _____ Glasses: ____ Braces: ____

My child has permission to participate in all school field trips: Yes _____ No _____

If my child becomes ill or involved in an accident while at Alexandria Academy of Fine Arts and Science or while on a school trip and I cannot be contacted, I authorize AAFAS to act in place of the parent or guardian should any medical, surgical treatment, or hospitalization be required. It is understood that the Day School and Hospital authorities will make a bona fide effort to contact the parent or guardian before acting on the authorization.

Signature required: _____ Date: _____

If parent(s) can not be reached and the child is sick or has minor injury, this person is authorized to pick the child up:

Name: _____ Phone: _____

Relationship to child: _____