

7010 Braddock Road
Annandale, VA 22003

STUDENT EMERGENCY INFORMATION

Student's name: _____ Home #: () _____

Mother/Guardian's Name: _____ Work #: () _____

Cell #: () _____

Father/Guardian's Name: _____ Work #: () _____

Cell #: () _____

Home address of student: _____

Legal guardian of student: _____

Child lives with: _____

Child's Social Security #: _____

***In the event of an emergency, please list 3 people who we could contact for assistance.
These people would be authorized to pick up your child in an emergency.***

	<u>Name</u>	<u>Phone#</u>	<u>Relationship</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Child's health insurance company: _____

Policy#: _____ Medicaid #: (if applicable) _____

If there is any other information that would be helpful in case of an emergency, please provide it below:

Does your child have allergies? If so, please explain below (include food, medication, etc.):

PROFESSIONAL CONTACTS

Please list any professionals who are working with your child (ex. psychologist, probation officer, social worker, etc.):

<u>Name</u>	<u>Agency</u>	<u>Phone#</u>
_____	_____	_____
_____	_____	_____

Date: _____

Signature: _____

PHILLIPS Programs ~ Annandale Campus

I give permission to PHILLIPS Programs to administer first aid treatment to my child in the case of an emergency and transportation of my child to a medical center or hospital if necessary. I give this permission for the duration of his/her enrollment at PHILLIPS.

I authorize the hospital and medical personnel to administer any emergency treatment required.

Child's Name: _____

DOB: _____

Parent/Guardian Signature

Date

Medical personnel may contact:

**Deb Scott, Program Director
Lindsay Harris, Program Director
Tamara Johnston, Program Supervisor
Laura Heyer, Program Supervisor
Stacie Thompson, Program Supervisor**

7010 Braddock Road
Annandale, VA 22003
Phone: 703-941-8810
Fax: 703-658-2378

PHILLIPS Programs

Emergency Care Information

*In case of an emergency, the school staff will contact 911.
Every attempt will be made to contact a parent, a guardian, or designated emergency contact.*

Student Information

Last Name: _____ **First Name:** _____ **Middle:** _____

Date of Birth: _____

Gender: Male or Female

Grade: _____

Current Health Conditions

Below check any current health condition that may require attention during the school day.

Allergies (be specific)

Foods _____

Medicines _____

Bee sting or insect bite _____

Other _____

Hemophilia

Physical disability _____

Respiratory _____

Seizures

Asthma

Vision problems

Cancer

Diabetes

Hearing problems Hearing aids

Heart problems (be specific)

Others (be specific)

List all medications and dosages your child take on a continual basis:

Physician Information

My child's medical care is provided by: _____
(Name of doctor, clinic, or HMO)

My child's medical coverage is provided by: _____
(Health insurance company, assistance program, HMO, etc.)

The school has my permission, in an emergency when I cannot be contacted, to take my child to the nearest appropriate medical facility, and the facility and its medical staff have my authorization to provide treatment that a physician deems necessary for the well being of my child.

Parent/Guardian Signature: _____ **Date:** _____