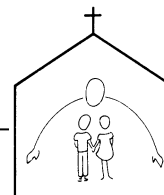


Emmanuel Lutheran Preschool 2012-2013
Emergency Contact/Emergency Pickup Information



Child's Full Name _____

TWO EMERGENCY CONTACTS WHO ARE AUTHORIZED TO PICK UP MY CHILD IN THE EVENT OF AN EMERGENCY AND/OR WHEN PARENTS CANNOT BE REACHED:

Emergency contacts must be in the immediate area and readily available. These two are NOT the child's parents.

Name _____	Name _____
Relationship _____	Relationship _____
Address _____	Address _____
Home Phone _____	Home Phone _____
Cell Phone _____	Cell Phone _____
Other _____	Other _____

All Persons Authorized to Deliver/Pick-Up Children

Please provide the following information about the persons who will be transporting your child to and from the preschool. (**Include the names of child's parents/guardians.**) For your child's safety, he/she will be released **ONLY** to the persons listed on this form. Any other arrangements must be authorized by the parent/guardian *in writing*.*

Name	Relationship to Child	Phone Number	Alt. Phone #
<u>Parent:</u>			
<u>Parent:</u>			
<u>Other:</u>			

*In case of an emergency where you will have someone other than those persons listed above pick up your child, please call the preschool office at (703) 938-6187 for authorization.

By signing this form you are agreeing to pick up your child in a timely manner when notified by us that this is necessary.

Parent/Guardian Signature _____

Date _____

PLEASE FILL OUT THE BACK OF THIS FORM

**Fairfax Hospital Association
Authorization for Emergency Treatment**

I, _____, hereby authorize:
(parent or guardian)

Any physician, member of the Department of Emergency Medicine of Inova Fairfax Hospital, Reston Hospital
OR Fairfax Access and/ or any member of the Medical Staffs of the above mentioned hospitals requested by the
Department of Emergency Medicine Physicians, to render any medical treatment, which in his/her judgment may
be deemed necessary in the care of _____.
(child)

Child's Allergies _____

Child's Doctor _____ Phone # _____

Medicines child takes regularly _____

Last tetanus shot _____

Outstanding Medical History (Diabetes, heart disease etc.) _____

Insurance Information

Insurance Company _____

Identification/Policy # _____

Subscriber's name _____

Place of Employment _____

Subscriber's telephone # _____