

Parental Consent

St. Matthew's Lutheran Day School ♦ 12351 All Saints Place ♦ Woodbridge, VA

Date: _____

In case of emergency, I (we), in the event of my (our) unavailability, hereby authorize the faculty and staff of St. Matthew's Lutheran Day School to grant permission for any medical or surgical treatment by the medical staff of Potomac Hospital, or by the Physician, if any, designated at the bottom hereof, on behalf of my (our) child (children), _____ (list names(s)).

Parent(s) or persons who were designated as emergency contacts at registration will be notified if a child becomes ill at school. Parents hereby agree to come in person or to direct their emergency contact to collect their child from school upon notification. No medications can be administered by school personnel unless prior written permission and directions are provided by the child's physician and parent.

This authorization covers the period from September 14, 2009 to May 25, 2010, inclusive*. Below, I have listed (i) all known allergies of each child; (ii) the date of the last tetanus shot for each child; and (iii) the name and telephone number of our family physician and/or pediatrician. Also, to comply with the requirements of Potomac Hospital, I have listed below hereof (i) the name of my health insurance company; (ii) its address; (iii) the number of my policy or contract; (iv) the name of the subscriber; and (v) the employer of the subscriber.

(*1st day of attendance through Tuesday preceding Memorial Day)

Further, the faculty and staff of St. Matthew's Day School is hereby notified that my (our) child (children) listed above has (have) my (our) permission to attend field trips with his/her (their) class (classes), subject to my (our) being informed in advance of destination and means of transportation.

I understand that photographs of class activities are occasionally posted on the school website. Children in photos are not identified by name. Photos which include my child may be posted.

Yes _____. No _____.

_____ phone _____ Cell phone # _____
(parent signature)

_____ phone _____ Cell phone # _____
(parent signature)

Name of nearest relative other than above: _____ Phone # _____

Known allergies of each child _____

List known illnesses and routine medicines given (list per child) _____

_____ (continue on reverse)

Date of last tetanus (DTaP) shot for each child: _____ (name/date)

Family Physician and/or Pediatrician: _____ phone # _____

Health Insurance Company: _____

Address: _____ Policy/Contract #: _____

Subscriber name _____ Subscriber's Employer _____