**PHILLIPS Programs ~ Fairfax**
**11230 Waples Mill Road, Suite 100**
**Fairfax, VA 22030**
**Phone 703-591-1146**
**Fax 703-591-1148**

## PERMISSION FOR EMERGENCY CARE

Student: ______________________ Birth Date: ______________________
Parent/Guardian: ______________________ Home Phone #: ______________________
Address: ______________________ Cell Phone #: ______________________
______________________ Work Phone #: ______________________
Email: ______________________

Parent/Guardian: ______________________ Home Phone #: ______________________
Address: ______________________ Cell Phone #: ______________________
______________________ Work Phone #: ______________________
Email: ______________________

* Emergency Contact: ______________________ Home #: ______________________
Relationship to Student: ______________________ Cell #: ______________________

Family Physician: ______________________ Phone #: ______________________
Referred Psychiatrist: ______________________ Phone #: ______________________

Does your child require the use of an EpiPen? ☐ Yes ☐ No (If yes, complete Epinephrine Authorization Form)
Does your child have Asthma? ☐ Yes ☐ No (If yes, complete Virginia Asthma Action Plan)
Does your child have Food Allergies? ☐ Yes ☐ No (If yes, complete Food Allergies Action Plan)
Does your child have any other known allergies? ☐ Yes ☐ No (If yes, list all known allergies)

Allergies:
______________________________________________
______________________________________________

Does your child have any other medical conditions, such as Epilepsy, Diabetes, etc. ☐ Yes ☐ No
If yes, list medical condition(s) and complete and attach an Emergency Treatment Plan.
______________________________________________

**For emergency purposes, list all medications taken by student:**

| Name of Medication | Total Mgs | Time | Reason | Side Effects |
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PHILLIPS Programs ~ Fairfax has my permission, in an emergency, when I cannot be contacted, to take my child to the emergency room of the Fair Oaks Hospital; and the hospital and its medical staff have my authorization to provide treatment deemed necessary by a physician for the well-being of my child.

______________________________ ______________________
Parent/Guardian Signature Date

** Emergency Contact must be someone other than the parent/guardian(s.)*
*This form is valid for one year from the date of signature.*