Granville Academy Northern Virginia

Medical Information & Permission for Emergency Care

(To be completed by parents)

Name of Pupil: _____ _____ _____ Date of Birth: _____
Last First M

Name of Program: Granville Academy Northern Virginia Date: _____

Name of Parent: _____ Home Phone: _____

Address: _____ Work Phone: _____
Mother

City: _____ State: ____ Zip: _____ Work Phone: _____
Father

Parent E-mail Address: _____

Parent/Guardian Insurance: _____

Insurance Company & Policy No: _____

Insurance Company Phone No: _____ Group No: _____

Granville Academy of Northern Virginia has my permission to call my family physician or other physician in an emergency when family physician or I cannot be contacted.

Name of Family Physician: _____ Phone No: _____

Is the student under physician's care for health needs on a continuing basis?

No: _____ Yes: _____ Please specify: _____

Does the pupil have any allergies? No: ____ Yes: ____ Please specify: _____

_____

The Granville Academy Northern Virginia has my permission, in an emergency when I or my physician cannot be contacted, to take my child to the emergency room of the nearest hospital, and the hospital and its medical staff have my authorization to provide treatment which a physician deems necessary for the well-being of my child.

Further Granville Academy Northern Virginia has my permission to dispense my child's medication and other medication (aspirin, Tylenol, Advil) deemed necessary for common ailments like headaches & stomach aches.

Signature of Parent/Guardian: _____ Date: _____

The original of this form shall be readily accessible and taken to hospital with patient.