

Emergency Form 2020-2021 SCHOOL YEAR



CHILD'S NAME _____ DOB _____ GRADE _____

CHILD'S ADDRESS _____

PARENT 1 NAME _____ HOME PHONE _____

CELL PHONE _____ E-MAIL _____

WORK PLACE _____ PHONE _____

PARENT 2 NAME _____ HOME PHONE _____

CELL PHONE _____ E-MAIL _____

WORK PLACE _____ PHONE _____

AUTHORIZED SCHOOL PICK UP CONSENT

| | | | |
|----------------------------|--------------|----------------------------|--------------|
| NAME OF AUTHORIZED PICK UP | RELATIONSHIP | NAME OF AUTHORIZED PICK UP | RELATIONSHIP |
| PHONE _____ | _____ | PHONE _____ | _____ |

| | | | |
|----------------------------|--------------|----------------------------|--------------|
| NAME OF AUTHORIZED PICK UP | RELATIONSHIP | NAME OF AUTHORIZED PICK UP | RELATIONSHIP |
| PHONE _____ | _____ | PHONE _____ | _____ |

ALTERNATE EMERGENCY CONTACT: List at least two persons authorized to pick up your child in an emergency if parents cannot be reached. These persons must be able to pick up your child within 30 minutes of receiving a call from school requesting that the child be picked up.

NAME _____ RELATIONSHIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

NAME _____ RELATIONSHIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

HEALTH INFORMATION

CHILD'S PHYSICIAN OR SOURCE OF HEALTH CARE _____

PHONE _____ PHYSICIAN'S ADDRESS _____

INSURANCE PROVIDER _____ POLICY # _____ GROUP # _____

MEDICAL CONDITIONS: Please provide documentation from your child's physician of any known medical condition.

(diabetes, asthma, known allergies: medicine, food, bee stings, etc.) If signs/symptoms appear: _____

_____ Medicines taken by child: _____

Signs/symptoms to look for: _____

_____ Date of last tetanus shot _____

EMERGENCY TREATMENT CONSENT

In the event that I cannot be reached, I hereby authorize a representative from WSB to transport my child to the Emergency Room of the nearest hospital medical personnel deem appropriate, and I hereby grant my consent for the hospital and its medical staff to provide my child with emergency medical treatment which a physician deems necessary (including anesthesia). I agree to accept financial responsibility for all medical expenses incurred.

PARENT SIGNATURE _____ DATE _____ PARENT SIGNATURE _____ DATE _____

BLANKET FIELD TRIP PERMISSION

I grant permission and authorize my child to accompany his/her class at the Waldorf School of Baltimore on all curricular field trips connected to class work which do not include an overnight stay (but may involve a return after 3:30 p.m. – the usual close of school.) An alternative form will be issued for overnight trips. I understand that transportation will be by walking, school activity bus, and/or public/private transportation unless I am otherwise notified. **I understand that advance notification with important details of trips will always be made one week in advance of any excursion.**

PARENT SIGNATURE _____ DATE _____

BLANKET SUNSCREEN AUTHORIZATION

I authorize my child's use of sun block during the school day and during school activities (field trips, camping trips, etc.) as needed. Sunscreen to be provided by the family.

PARENT SIGNATURE _____ DATE _____

PHOTO & VIDEO CONSENT

I hereby grant the Waldorf School of Baltimore (WSB) permission to use photographs and video footage of my child taken during school-sponsored activities for publicity and/or educational purposes. This may include, but is not limited to, the WSB website, newsletter, social media, and or print materials. I understand that if my child's image is used, all efforts will be taken to safeguard their privacy.

CHILD'S NAME _____ PARENT SIGNATURE _____ DATE _____

PARENTS MUST NOTIFY THE OFFICE OF ANY VITAL INFORMATION CHANGES. THANK YOU.