

# Emergency Contacts and Health Information

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_ Year \_\_\_\_\_

Mother's Name _____	Address _____
Place Employed & Address _____	
Phone numbers _____	home _____ work _____ cell/beeper _____
Father's Name _____	Address _____
Place Employed & Address _____	
Phone numbers _____	home _____ work _____ cell/beeper _____

Please provide the names and phone numbers of two additional relatives or friends **who could be called to pick up your child should we be unable to reach you.**

Name & Address _____	
Phone numbers _____	home _____ work _____ cell/beeper _____
Name & Address: _____	
Phone numbers _____	home _____ work _____ cell/beeper _____

Child's allergies or medical conditions _____
Prescribed medications the child takes regularly _____
Any known adverse reaction to any sunscreen _____
Any known adverse reaction to any insect repellent _____

### ANALGESIC AND/OR HOMEOPATHIC FIRST-AID TREATMENT CONSENT

I hereby grant my permission to the faculty and staff of Charlottesville Waldorf School to administer the following non-prescription drugs and medications to my child according to the age/weight specifications of the manufacturer:

\_\_\_\_\_ Acetaminophen (Tylenol)    \_\_\_\_\_ Ibuprofen (Advil)    \_\_\_\_\_ Benadryl

\_\_\_\_\_ I hereby grant my permission to the faculty and staff of Charlottesville Waldorf School to administer appropriate homeopathic remedies to my child.

\_\_\_\_\_  
Parent's or Guardian's Signature