

**EMERGENCY CONTACT AND MEDICAL AUTHORIZATION
OLD DOMINION DAY SCHOOL INC.**

Child's Name	Date of Birth	M F Sex
Home Street Address	City	State Zip
Parent/Guardian Name	Parent/Guardian Name	
Address (if different from Child)	Address (if different from child)	
City, State, Zip (if different from child)	City, State, Zip (if different from child)	
Home Phone Number	Home Phone Number	
Cell Phone Number	Cell Phone Number	
Employer Name	Employer Name	
Work Phone Number	Work Phone Number	

MEDICAL INFORMATION

HOSPITAL PREFERENCE _____

PEDIATRICIAN NAME _____ PEDIATRICIAN PHONE NUMBER _____

ALLERGIES/SPECIAL HEALTH CONSIDERATIONS _____

The parent(s)/guardian(s) authorize OLD DOMINION DAY SCHOOL INC. to obtain immediate medical care and consents to the hospitalization of, the performance of necessary diagnostic test upon, the use of surgery on, and/or the administration of drugs to his/her child or ward if and emergency occurs when he/she cannot be located immediately. It is also understood that this agreement covers only those situations which are true emergencies and only when he/she cannot be reached. Otherwise he/she expects to be notified immediately.

I/We will be responsible for payment of medical care expenses. Medical treatment costs are covered by:

INSURANCE COMPANY _____ POLICY NUMBER _____

DATE _____ PARENT SIGNATURE _____

DATE _____ PARENT SIGNATURE _____