



# Shenandoah Valley Christian Academy

P.O. Box 1360 ♦ Stephens City, VA 22655 ♦ P: 540.869.4600 ♦ F: 540.869.4662  
www.svca.net www.svcasports.net

## Student Emergency Information

2007-2008 Academic Year

*Please complete each section.*

Student Name (First, middle, last)		
Date of Birth:	Grade:	
Parent/Guardian:	Mother's Name:	
Physical Home Address:	Home Phone:	
Mother's Work Phone:	Mother's Cell:	Other:
Father's Work Phone:	Father's Cell:	Other:

Medical conditions and/or allergies (including reactions to medication): \_\_\_\_\_

Current Medications: \_\_\_\_\_

(A 72 hour supply of life-sustaining medications should be kept at the school)

Are there any physical or medical conditions we should know about? \_\_\_\_\_

Physician:	Phone:
Dentist:	Phone:
Health Insurance Carrier:	Policy #:
Under the name of:	Relationship:
Preferred hospital:	Date of last tetanus shot:

**In case of emergency, the following individuals are authorized to be contacted and/or have my permission to pick up my child from school. (Please notify these individuals that you have given them this authorization.)**

Name	Phone
Name	Phone
Name	Phone

Initial if school staff may administer: \_\_\_\_\_ Aspirin; \_\_\_\_\_ Tylenol; \_\_\_\_\_ Ibuprofen; \_\_\_\_\_ None

\_\_\_\_\_  
Father's Signature Date Mother's Signature Date

No records or information will be released outside the school without parental consent. Faculty and staff have limited access to these records.

*Please notify the school office of any changes during the school year.  
Please complete the Emergency Medical Release on the reverse side.*

***Signatures Needed on Reverse Side***

**Shenandoah Valley Christian Academy**  
**Emergency Medical Release**  
2007-2008 School Year

***Both parents*** of the student must sign. If parents have joint custody of the child and live in separate homes, both parents are required to sign this form. This form will be on file in the school office for the current school year.

In case of accident, illness, or other emergency, to my child \_\_\_\_\_, whose birthday is \_\_\_\_\_, I/we request that the school contact me/us. If the school cannot reach a parent/guardian after conscientious effort, I/we give permission for school staff to call paramedics or any licensed physician or dentist. If a life-threatening emergency exists, I/we give permission for school staff to call paramedics immediately and then contact me/us as soon as possible thereafter.

I/we authorize and consent to any x-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care, which in the best judgment of a licensed physician or dentist is deemed advisable. I/we agree to assume the financial responsibility for expenses incurred as a result of those services being provided. I/we also agree to be financially responsible for emergency medical transportation.

\_\_\_\_\_  
Father/Guardian Signature

\_\_\_\_\_  
Mother/Guardian Signature

\_\_\_\_\_  
Father/Guardian Printed

\_\_\_\_\_  
Mother/Guardian Printed

Date \_\_\_\_\_

Date \_\_\_\_\_

*Please notify the school office of any changes during the school year.*