DESMOND T. DOSS CHRISTIAN ACADEMY
19 George Street
Lynchburg, VA 24502
434-237-1899

EMERGENCY CONSENT FORM 20___-___

Family's Last Name: _____

Children's Names: 1)_____ Birthdate: _____

2)_____ Birthdate: _____

3)_____ Birthdate: _____

4)_____ Birthdate: _____

Home Street Address: _____

City/State: _____ Zip Code: _____

Parent/Guardian's Name: _____

Home Phone: ( ) _____ Cell: ( ) _____

Cell: ( ) _____

Email Address: _____ ☐ *Yes, I wish to receive information such as letters, absence/tardy info, etc. via email from schoolsecretary@live.com*

Mother's Work Phone: ( ) _____ Other: _____

Father's Work Phone: ( ) _____

Relative/Friend to contact in case of illness/emergency:

Name: _____ Phone ( ) _____

Name: _____ Phone ( ) _____

Primary Physician's Name: _____

Address: _____

Phone: ( ) _____

Hospital Preference: _____

In case of accident or serious illness, if the school is unable to contact me, I hereby authorize the school to take my child to the physician indicated above. If it is impossible to contact the physician, the school may take my child to a hospital authorized by the Board of Health or to the relative or neighbor listed above.

Parent/Guardian Signature: _____ Date: _____

PLEASE FILL OUT EMERGENCY PUPIL RELEASE FORM ON REVERSE SIDE

This child may be picked up by:

NAME	RELATIONSHIP TO CHILD

Identification question may include:

- ✓ Who are you?
- ✓ What is your relationship to this child?
- ✓ Do you have a photo ID?

_____ _____

Signature of parent Date

Comments: (Please list any issues or special circumstances concerning pickup below)

_____

_____

_____

_____

Please save your completed form to your hard drive, then email it to info@desmondtdoss.org.
NOTE: Be sure you attach the completed PDF form(s) to your email before you hit *Send*.