HS-5
(Rev. 7/06)

Winston-Salem/Forsyth County Schools
Winston-Salem, N.C.
PERMISSION TO SECURE MEDICAL CARE

Dear Parent or Guardian: **School**_____________________

It is extremely important that the school have on file current information for emergency use regarding your place of employment, work hours, names and telephone numbers of neighbors, relatives, baby-sitters, and child care providers. Please make an effort to keep this information on your child's record up-to-date.

In the event that your child becomes seriously ill or injured while at school, the school will take action as outlined below:

1. **Appropriate first aid will be administered immediately when the situation calls for it.**

2. **In extreme emergencies, your child will be taken immediately to the hospital emergency room by ambulance or private vehicle and you will be contacted and advised of the situation. In most cases, however, efforts will be made to contact you first and to seek your advice concerning the action to be taken by the school.**

3. **In the event you cannot be located or in extreme emergencies, the school officials will decide whether immediate medical treatment is needed and will act accordingly.**

In order to assure that proper medical treatment can be obtained under the conditions described in section #3 above, the school system requests that you complete the form below giving the school permission to obtain medical treatment for your child and certifying that you will accept the financial responsibility for payment of any ambulance, hospital and/or physicians' bill and charges.

I, the undersigned, give permission to the Winston-Salem/Forsyth County School System and my child's school to act in my behalf in my absence or in emergency situations to obtain medical treatment for my child_________________________

I agree to accept full responsibility for the payment of all ambulance, hospital and physicians' bills and charges for any services rendered.

Medical Insurance/HMO:____________
Policy Number: ____________________
Check your preference: WFU Baptist Hospital______
Forsyth Hospital_________
Other_________________

Family Doctor__________________
Telephone____________________

____
Name of Nearest Relative
Telephone Home_____________
Work_____________

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Signature of Parent or Guardian
Date:__________________________
Telephone Home_______________
Work_______________
Work Hours_______________

____
Name of Friend, Neighbor/Child Care Provider
Telephone Home_____________
Work_____________