

Washakie County School District #1

EMERGENCY INFORMATION FOR ALL STUDENTS

PLEASE PRINT IN INK!

Parents: Please fill in all spaces

NAME _____ BIRTH DATE _____ AGE _____
PARENT/GUARDIAN'S NAME _____ GRADE _____
ADDRESS _____ HOME PHONE _____
FATHER'S BUSINESS PHONE _____ MOTHER'S BUSINESS PHONE _____

In an emergency, if parents cannot be contacted:

NOTIFY _____ PHONE _____
FAMILY PHYSICIAN _____ PHONE _____
KNOWN ALLERGIES _____
ANY MEDICATION BEING TAKEN _____
REASON _____

DOES STUDENT WEAR GLASSES? YES _____ NO _____
DOES STUDENT WEAR CONTACT LENSES? YES _____ NO _____
SEMI HARD _____ HARD _____ SOFT _____

<u>HEALTH HISTORY</u>	YES	YES
KIDNEY INJURIES	_____	BONES/JOINT/ORTHOPEDIC _____
HEART CONDITION	_____	SEIZURES _____
DIABETES	_____	OTHER _____
ASTHMA	_____	

REOCCURRING INJURIES _____

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INSURANCE COMPANY _____ POLICY # _____

NAME OF INSURED _____

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I hereby authorize Washakie County School District #1 and its faculty members in charge of my son/daughter named above to obtain all necessary medical care for my son/daughter in the event that I cannot be reached to authorize it myself. I hereby authorize any licensed physician and/or medical personnel to render necessary medical treatment to my son/daughter.

DATE SIGNATURE OF PARENT/GUARDIAN

Signature acknowledges that I have read and understood the above statement and I give consent for emergency medical assistance that might be needed.