Woodland Country Day School

STUDENT EMERGENCY AND MEDICAL INFORMATION CARD for 2017-2018 Academic Year

(Fill out siblings in order oldest to youngest)

Student's Name (First, Last):_____ Date of Birth:_____ SS#_____

Student's Name (First, Last):_____ Date of Birth:_____ SS#_____

Student's Name (First, Last):_____ Date of Birth:_____ SS#_____

Home Address: _____Home Phone: _____

Father's Name: _____ Mother's Name: _____

Father's Occupation: _____ Mother's Occupation: _____

Father's Work Address: _____ Mother's Work Address: _____

_____ _____

Father's Work Phone: _____ Mother's Work Phone: _____

Father's Mobile Phone: _____ Mother's Mobile Phone: _____

Father's Fax Number: _____ Mother's Fax Number: _____

Father's Email: _____ Mother's Email: ___ _____

Father's SS# _____ Mother's SS# _____

Family Physician's name and telephone number to contact in case of emergency:

Physician's Name: _____ Telephone: _____

PERSON(S) TO CONTACT IN THE EVENT IF NEITHER FATHER, MOTHER OR LEGAL GUARDIAN CAN BE REACHED:

(Grandparent, neighbor, friend, relative, etc. who could be reached during school hours and would assume temporary care of the child.)

Name: _____Telephone: _____Relationship: _____

Other persons (if needed): _____

Allergies:

Name: _____ Allergies: _____

Name: _____ Allergies: _____

Does your child (or children) listed have a severe reaction to a bee sting or other severe reaction? (yes)_____ (no) _____

State which: _____

Any instructions? _____

Side 1

Note: THERE ARE TWO PAGES TO THIS FORM. ALL INFORMATION MUST BE COMPLETED.

Prescriptions and Medications: (Note: The School will administer **NO** medications EXCEPT: prescription and non-prescription medicine accompanied with a signed order by the family physician and a note from the parent. This is kept on file in the nurse's office. **THERE ARE NO EXCEPTIONS TO THIS POLICY, AS IT IS A STATE REGULATION.**

Name: _____ Medicine: _____

Name: _____ Medicine: _____

Any illness, surgical procedure or immunization during the school year 2016-2017? (Explain): _____

_____

In order for us to maintain accurate records, please complete the following information:

Paternal Grandparents: **Maternal Grandparents:**

Name: _____ Name: _____

Street: _____ Street: _____

City: _____ City: _____

IF THERE ARE ANY CHANGES IN THE INFORMATION PROVIDED, PLEASE NOTIFY THE SCHOOL.

I hereby give permission to release information regarding my child's health condition(s) to school personnel in order to best meet the medical and health needs of my child in the school setting.
In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, the school may make necessary arrangements to treat my child.

Signature of Parent or Guardian: _____ Date:_____

IS THERE ANY PERSON(S) WHO SHOULD NOT HAVE CONTACT WITH YOUR CHILD (CHILDREN)? IF SO, LEGAL DOCUMENTATION AND A NOTE FROM THE PARENT/GUARDIAN MUST BE SUBMITTED TO THE SCHOOL OFFICE.

Name of Person(s): _____

_____

Signature of Parent or Guardian: _____Date:_____