W.C.C.A.

EMERGENCY MEDICAL INFORMATION

Please fill out all information requested below

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Please Print

Student Social Security #_______-_______-_______

Student's Full Name: ____ Present Age: _______
(last) (first) (middle)

Date of Birth:________________________________ Sex: Male/Female
(year) (month) (day) (circle one)

Father's Name:____
(Last) (First) (Middle)

____
(address)
Phone: (Home)____________ (Work)___________ (Cell)______________

Mother's Name:____
(Last) (First) (Middle)

____
(address)
Phone: (Home)____________ (Work)____________ (Cell)_____________

If parents are separated, with whom does the child live? ___________________________
Alternate Emergency Information: Persons to contact if parents/guardian are unavailable:

____
(Name) (Telephone No.) (Relationship)

____
(Name) (Telephone No.) (Relationship)

In case of accident or serious illness, I request the school to contact me or the emergency numbers above. However, if the school is unable to reach me or the emergency persons, I hereby authorize the school to call the physician indicated below and to follow his instructions. If the physician cannot be reached, I request the school to make whatever arrangements necessary with the understanding that I am responsible for any and all medical bills not covered by insurance.

(Parent's Signature) ____________________________________

Physician's name:_______________________________ Telephone No.______________

Does your child have any special medical problem or allergies that the school should be aware of?
Yes___. No___. If Yes, please explain____

The school is authorized to give my child Tylenol and/or Advil Yes____, No ____

The school is authorized to give my child Benadryl, Yes ____, No ____

The school is authorized to give my child an antacid, Yes ____, No ____

Does your child take any other medication? Yes ____, No ____. Please specify with instructions.

____

Other children's name and grade if enrolled in THIS school:_____________________________________

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