White Pass School District **White Pass Jr. Sr. High School**

EMERGENCY INFORMATION RECORD

Name of Student _____ Birthday _____

Parent/Guardian_____ Legal Custody: Yes____No____

Mailing _____ City _____ Home _____

Physical _____ City _____ Message _____

Father's Name _____ Home _____ Work _____

Mother's Name _____ Home _____ Work _____

IN CASE OF EMERGENCY AND PARENT/GUARDIAN IS NOT AVAILABLE, CONTACT:

Name: _____ Home _____ Work _____

Name: _____ Home _____ Work _____

Name: _____ Home _____ Work _____

Student's Physician_____ Phone _____

Hospital where student should be taken if parent or physician is unavailable: _____

_____

AGREEMENT AND CONSENT FOR TREATMENT AND EMERGENCY TRANSPORT:

Should my child require medical treatment, transportation or hospitalization for any accident or illness during school or while participating in a school activity, the attending physician, emergency medical technician or hospital is authorized to release diagnostic and treatment information as may be needed to complete any insurance claim.

In addition, this is to certify that I, the undersigned parent or guardian, hereby consent to and authorize the administration and performance of all needed medicines (and surgical treatment) and the administration of any anesthetic which in the opinion of the attending physician, may be necessary and advisable in the event of any medical emergencies regarding my son or daughter.

Student's name_____ Date_____

Signature of parent/guardian_____

PLEASE LIST ALLERGIES AND OTHER MEDICAL CONDITIONS:

Allergies: Plants ____ Foods ____ Bees or Insects ____ Drugs ____ Animals ____ Other _____

Describe the reaction: _____

Name of Medication needed for the allergy: _____

Other medical conditions: _____

Name of Medication needed for conditions: _____

List any medications needed at school*: _____**

***** Please complete the Authorization for Administration of Medication at School form, also.**

Additional Comments: _____

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