White Pass School District — White Pass Elementary

STUDENT INFORMATION

Parents: Please help us update our information by completing and returning to school.

Name of Student ______________________________ Birthday ____________

Grade ______ Teacher ______________________

Address:

Mailing ______________________________ City ____________ Phone ______________

Physical ______________________________ City ____________ Cell Phone ____________

Father's Name ____________________________ Work Phone __________ Pick-up? Yes No

Mother's Name ____________________________ Work Phone __________ Pick-up? Yes No

Step Parent's Name _________________________ Work Phone __________ Pick-up? Yes No

Emergency Contacts

Name: ______________________________ Phone ______________ Pick-up? Yes No

Name: ______________________________ Phone ______________ Pick-up? Yes No

Student's Physician's Name _______________________________ Phone ______________

The school will use its best judgment in obtaining emergency medical care for unusual accidents or illnesses if none of the responsible persons listed on this form can be contacted.

____ ______________

Parent or Guardian's Signature Date

Check the ones that apply for your child:

____	Asthma	____	Frequent Earaches	____	Dental Problem
____	Hay Fever	____	Frequent Headaches	____	Frequent Stomach Ache
____	Diabetes	____	Frequent Colds	____	Frequent Urination
____	Bleeder	____	Frequent Sore Throats	____	Bedwetting
____	Heart Disease	____	Fainting Spells	____	Color Blindness
____	Bone Disease	____	Seizures	____	Physical Handicap
____	Tires Easily	____	Speech Difficulty	____	Frequent Nose Bleeds
____	Clumsiness	____	Poor Appetite	____	Vision Problem
____	Kidney Disease	____	Hearing Problem	____	Learning Problems

Comments regarding any of the above: ____

____

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

Describe the reaction: ____

Is medication needed for the allergy? Yes _____ No _____ Name of Medication ______________

Additional Medication for any other condition: Name of Medication ____________________

Will it need to be given at school? Yes _____ No ______

Additional Comments: ____

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8/01