

Student Emergency Information Evergreen Christian School Olympia, WA

Student Name _____ Birthday _____ Grade _____
 Parent/Legal Guardian Name(s) _____
 Home Phone _____
 Home Address _____ City _____ ZIP _____
 Work Phone _____ Work Phone _____
 Cell Phone _____ Cell Phone _____

Alternate Persons to be notified in Case of Emergency:
 Name _____ Relationship _____ Phone _____
 Name _____ Relationship _____ Phone _____

Physician of Choice _____ Phone _____
 Preferred Hospital _____ Phone _____
 Insurance Provider _____ Policy # _____

Yes	No*	If the parents and authorized physician named above cannot be reached at the time of an emergency, and if immediate observation or treatment in the judgment of the school authorities, do you authorize and direct the school authorities to send the pupil (properly accompanied) to the hospital or doctor most easily accessible?
Yes	No*	Do you agree to be financially responsible for all expenses incurred for the treatment under the circumstances described above?
Yes	No*	If an ambulance is called, do you agree to be financially responsible for the expenses incurred?

*Please explain what action you desire the school authorities to take: _____

Has your Child had:
 Vision Problems _____ Glasses: Yes No Contact Lens: Yes No
 Hearing Problems _____ Speech Problems _____

Please Check if Your Child is Being Treated for Any of the Following:
 Epilepsy _____ Diabetes _____ Asthma _____

Check if your child uses one of these items: Inhaler Epi-pen
 If so, who will keep the item: Student Teacher Office

Allergies (please describe)

 List any medications your child is allergic to _____
 If your child is on medication or receiving treatment, please specify here: _____

List any other information relative to your child's health or special circumstances which the nurse should know:

I understand that a copy of the AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL form is included in the *Evergreen Christian School Parent/Student Handbook* and is also available upon request in the school office. In addition, physicians and dentists have appropriate forms available in their offices.

Parent/Legal Guardian Signature _____ Date _____

For Office Use Only in Case of Disaster	
First Aid Provided for Student:	
Name of Individual to Whom Student is Released:	Signature of Individual to Whom Student is Released:
Time Released:	Destination of Student: