**EMERGENCY INFORMATION** Date _____ Student's (students') LAST NAME _____
Please Print

IMPORTANT! RETURN BY THE FIRST DAY OF SCHOOL New Address or Telephone Check Here ☐

Student's Name(s) _____ Grade(s)_____ Date of Birth _____

Parents' Names _____

Home Address _____ City _____ Zip _____ Phone: _____

Place of Work: Father _____ Work Phone: _____ Cell: _____

Mother _____ Work Phone: _____ Cell: _____

**Local** person to contact if parents are not available: (**This must be filled out.**)

1. Name _____ Phone: _____ Cell: _____
2. Name _____ Phone: _____ Cell: _____

Student lives with: Parents ○ Mother ○ Father ○ Grandparents ○ Other _____

Person to contact ***outside*** the Puget Sound area: **(This must be filled out.)**

1. Name _____ Phone: _____ Cell: _____

Does your child have any health conditions we should be aware of? ○ Yes ○ No
If YES, please indicate:

☐ Asthma ☐ Bee sting allergy ☐ Convulsive seizures ☐ Heart ☐ Arthritis ☐ Diabetes
☐ Deafness ☐ Kidney/Bladder ☐ Sight Impairment ☐ Wears glasses ☐ Wears contacts
☐ Other allergy (list): _____ ☐ Mild ☐ Severe

Identify activities that child(ren) should NOT participate in: _____

**---PLEASE FILL OUT REVERSE SIDE---**

**PLEASE PRINT! ------COMPLETE TOP and BOTTOM THE SAME -----School Office will separate -------PLEASE PRINT!**

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FAMILY DOCTOR _____ OFFICE PHONE _____

EYE DOCTOR _____ OFFICE PHONE _____

DENTIST _____ OFFICE PHONE _____

If emergency treatment is required, and the parents or legal guardian cannot be reached immediately, your signature in the space provided below empowers the school authorities to exercise their own judgment in calling the physician indicated above, or if not available, to transport the child to a hospital emergency room. Likewise, your signature below authorizes the release of medical records pertinent to such an emergency room visit. This is a general authorization and is not sufficient for the release of confidential information protected by Federal Law.

**SPECIAL NOTE:** PLEASE KEEP INFORMATION CURRENT.

What could emergency personnel do for your child that would be the most comforting and supportive? _____

_____

_____

**Child / Day Care Information:** Name: _____ Phone _____

PERSON(S) WHO HAVE YOUR PERMISSION TO TAKE YOUR CHILD / CHILDREN HOME IN CASE OF UNEXPECTED SCHOOL CLOSURE DUE TO THE WEATHER OR OTHER EMERGENCY. (This is only in the event that we cannot reach the parent.) Please let these people know that they can take your child(ren). **Include especially CARPOOL DRIVERS' names.**

1. Name Phone: _____ Cell: _____
2. Name _____ Phone: _____ Cell: _____
3. Name _____ Phone: _____ Cell: _____

PARENT'S SIGNATURE _____ DATE _____

**IMPORTANT NOTE: The Emergency Form must be in the school office by the first day of school.**

-------- PRINT! ----------Fill out BOTH copies fully ------ Office will separate ------- PRINT! ---------- PRINT! ----------

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EYE DOCTOR _____ OFFICE PHONE _____

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