

STUDENT EMERGENCY CARD

Student Name _____

Doctor _____ Phone _____

Dentist _____ Phone _____

**IN THE EVENT OF A LIFE-THREATENING INJURY, STUDENTS
WILL BE TRANSFERRED TO THEDA-CLARK HOSPITAL OR
THE CLOSEST HOSPITAL.**

Does your child have any health conditions of which the school should be aware? If yes, please write them on these lines _____

I hereby authorize treatment, administration of anesthesia surgical treatment(s) for my minor son/daughter, in the event of a medical situation occurring during my absence or when the hospital or physician(s) and nursing personnel within the hospital or employed by the physician as well as any physician and physician's office determine such treatment to be necessary.

Signed this _____ day of _____ 2008

Valid until the 4th day of June, 2009.

Signature of Parent/Guardian

Insurance Company: _____ Policy # _____

2nd Insurance Compnay _____ Policy # _____

Please complete both sides.....

STUDENT EMERGENCY CARD

Student Name: _____	Parents: Father: _____	Mother: _____
Date of Birth: _____	Home Phone: _____	Home Phone: _____
Home Phone: _____	Cell Phone: _____	Cell Phone: _____
Home Address: _____	Address (if different): _____	Address (if different) _____
City _____	_____	_____
State _____ Zip _____	State _____ Zip _____	State _____ Zip _____
	Place of Employment: _____	Place of Employment: _____
	Work Phone Number _____	Work Phone Number _____

In case of an emergency, and the inability to contact a parent/guardian, please contact one of the following:

	<u>Name</u>	<u>Relationship</u>	<u>Telephone</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Please complete both sides.....