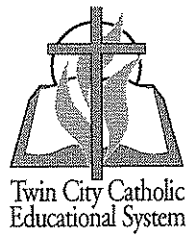


STUDENT EMERGENCY CARD



Student Name(s):

Date Of Birth _____

Date Of Birth _____

Date Of Birth _____

Date Of Birth _____

Father: _____

Home Phone: _____

Cell Phone: _____

Address: _____

City: _____ Zip _____

Place of Employment: _____

Work Phone Number: _____

Mother: _____

Home Phone: _____

Cell Phone: _____

Address (if different): _____

City: _____ Zip _____

Place of Employment: _____

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 Number(s)</u>
1.	_____	_____	H/W: _____ cell: _____
2.	_____	_____	H/W: _____ cell: _____

Please complete both sides

STUDENT EMERGENCY CARD



Family Name: _____

Doctor: _____ Phone #: _____

Insurance Company: _____ Policy #: _____

Dentist: _____ Phone #: _____

Insurance Company: _____ Policy #: _____

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

Does your child/ren have any health conditions of which the school should be aware?

If yes, please explain on the lines below.

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 staff where treatment is rendered in the physician's office determine such treatment to be necessary.

Signed this _____ day of _____, 2011.

Valid until the 6th day of June, 2012.

Signature of Parent/Guardian