WJCC EMERGENCY INFORMATION CARD

School	School Year

SCHOOL USE ONLY

Homeroom/ 1st Block Room #
Teacher Name
Grade

PLEASE COMPLETE THIS ENTIRE FORM.
The information below has changed from last year: ☐ YES ☐ NO

STUDENT NAME (Last, First, Middle)	DOB

PERMANENT ADDRESS (Must Have Number and Street Name)	CITY	ZIP

MOTHER/GUARDIAN FULL NAME (Last, First, Middle)	HOME PHONE	WORK PHONE/Ext.	CELL PHONE
FATHER/GUARDIAN FULL NAME (Last, First, Middle)	HOME PHONE	WORK PHONE/Ext.	CELL PHONE

I authorize the following individuals to assume temporary care of my child if I cannot be reached:

CHOICE	NAME	RELATIONSHIP	ADDRESS	DAYTIME PHONE
1st				
2nd				
3rd				

MUST COMPLETE REVERSE SIDE

***Does this student have Health Insurance? (Private, Medicaid, FAMIS) YES ❑ NO ❑ If no, and you would like information about State Health Insurance call FAMIS toll free at 1-866-873-2647 or contact your local Department of Social Services.**

The information below is CONFIDENTIAL and will only be shared with appropriate staff on a need to know basis or with EMS in emergency situations.** ***If your child has a noted health problem(s) that may affect him/her in the school setting, it is the parent's/guardian's responsibility to notify the appropriate staff, including the school nurse.

Please note any type of physical limitation, disability, chronic illness, or allergy your child may have. Describe the health problem below along with any special instructions for care. Please inform us in writing if this information cannot be shared with staff members on a need-to-know basis.

MEDICAL DIAGNOSIS AND/OR HEALTH PROBLEM(S):

ALLERGIES: To What:
What Happens:
Is this life threatening? ☐ YES ☐ NO (If yes, please contact the school nurse)

DAILY MEDICATION AT HOME:

DAILY MEDICATION AT SCHOOL:

In case of an accident or illness, I ask the school to contact me. If the situation is life-threatening or serious, I give permission for a rescue squad to transport my child to the closest medical facility. Should this occur, I give my permission for the medical facility to treat my child at my expense and to convey the treatment and diagnosis to a WJCC school nurse. I will immediately notify the school if any of the information changes during the year.

Local Physician Name

Office Phone No.

PARENT/GUARDIAN SIGNATURE

DATE: