WCS and Extended Care Emergency Update

WOODLAND CHRISTIAN
EST. 1974

Academic Year: _____/_____

What is your designated public school area?

Grade: **Teacher:**

Student Information:

Student's Name _____ Nickname _____
LAST FIRST MIDDLE (WHAT STUDENT WILL GO BY AT SCHOOL)

Birth date _____/_____/_____ Present Age_____ Male ☐ Female ☐ Soc Sec # (HS 11th & 12th only) _____

Home Address _____
(STREET, COUNTRY ROAD, ROUTE #) CITY STATE ZIP

Mailing Address _____

High School Only

Student Cell Phone # (_____)_____Home Phone (_____)_____☐Unlisted

PHOTO AGREEMENT: ☐ **YES** ☐ **NO**

☐ I grant permission for my child to be included in any photos the school may use for school newsletters, web pages, promotions, etc.

Parent / Guardian Information:

If Parents are divorced or separated, who has legal custody of the child? ☐ Mother ☐ Father ☐ Both ☐ Other _____

Parents' Status: ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Deceased ☐ Other_____

Student lives with: ☐ Father ☐ Step-father ☐ Guardian ☐ Other _____

☐ 100%
☐ 50%
☐ Weekends only
☐ Report Card
☐ Mailing list only
☐ NO Contact

Father or Guardian _____

Occupation _____

Place of Employment_____

Employer Address_____

Home Address_____
(If different than student)

Email:_____
☐ Home ☐ Work

CALL: ☐ **First** ☐ **Second** ☐ **Don't Call**

Work Phone (_____) _____

Extension: _____

Cell Phone (_____) _____

Home (_____) _____

☐ Unlisted

Are you an Alumni of WCS? ☐ Yes ☐ No

Parents' Status: ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Deceased ☐ Other_____

Student lives with: ☐ Mother ☐ Step-mother ☐ Guardian ☐ Other _____

☐ 100%
☐ 50%
☐ Weekends only
☐ Report Card
☐ Mailing list only
☐ NO Contact

Mother **or Guardian** _____

Occupation _____

Place of Employment_____

Employer Address_____

Home Address_____
(If different than student)

Email: _____
☐ Home ☐ Work

CALL: ☐ **First** ☐ **Second** ☐ **Don't Call**

Work Phone (_____) _____

Extension: _____

Cell Phone (_____) _____

Home (_____) _____

☐ Unlisted

Are you an Alumni of WCS? ☐ Yes ☐ No

Newsletters and Announcements will be sent via your email address. It is our desire to keep our families informed in a quick and efficient way. Please provide your email address(es) above that you would like the newsletter/announcements sent to:

☐ I do NOT have an email address and will need the newsletters/announcements sent home with my child.

Church Information

Does Student Attend Church? ☐ YES ☐ NO	Name of Church	Pastor
Does Family Attend Church? ☐ YES ☐ NO	Name of Church	Pastor

Emergency Contact and Pick-Up Release: Please list LOCAL ADULT(s) (18+ years of age) to be contacted in case of an emergency, list in order of preference. Include step-parent(s) (if applicable), etc. Please indicate if person is authorized to pick-up student from school or Extended Care.

Name	Primary Contact # Circle: Cell, Work, Home	Alternate Contact # Circle: Cell, Work, Home	Relationship	Allowed to Pick Up
1	C W H	C W H		☐ Yes ☐ No
2	C W H	C W H		☐ Yes ☐ No
3	C W H	C W H		☐ Yes ☐ No
4	C W H	C W H		☐ Yes ☐ No
5	C W H	C W H		☐ Yes ☐ No
6	C W H	C W H		☐ Yes ☐ No

Person(s) who may NOT PICK-UP child		

Physician:	Address:	Physician's Phone:
Dentist:	Address:	Dentist's Phone:
Hospital Preference:		
Insurer:	Group #:	Policy #:
Financial Responsibility:		

DOES YOUR CHILD HAVE ANY MEDICAL CONDITIONS OR ALLERGIES? (Please Check One) ☐ **YES** ☐ **NO If yes, please check all that apply**.

☐ ADD/ADHD ☐ Asthma ☐ Bee Sting ☐ Diabetes ☐ Hearing Loss ☐ A Heart Condition ☐ Migraines

☐ Severe Allergy/Anaphylaxis ☐ Other _____ Describe _____

Does your child need medication at SCHOOL? ☐ Yes ☐ No If yes, list medication(s) at school:

Medication at HOME? ☐ Yes ☐ No List medication(s) at home:

Doctor's and Parent Authorization with instruction must be on file to administer medication at school. **Authorization On File** ☐ **Yes** ☐ **No**

May student be given medication for headaches? ☐ Yes ☐ No Preference: ☐ Aspirin ☐ Tylenol ☐ Ibuprofen

Strength: ☐ Adult ☐ Junior ☐ Children

Physical Limitations: _____

Eyes: ☐ Glasses ☐ Contacts

EMERGENCY CARE PERMIT: When a child suffers any injury or illness while in school, an immediate and continuing effort will be made to contact the parents of that child. In the case of serious injury or illness, first aid will be rendered in accordance with school policies. If I cannot be reached by telephone, in the event of an emergency Involving the above named student, please call the physician listed below.

In case of serious illness or accident, I hereby authorize school officials to call any local physician or paramedic if the listed physician cannot be reached.

AUTHORIZATION TO TREAT A MINOR: I (We) the undersigned parent (s) or legal guardian of the above named student, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the medicine practice act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California, Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgement may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

An immediate and continuing effort will be made to contact the parents in case of serious injury or illness.

Parent/Guardian Signature: Date: