

STUDENT EMERGENCY INFORMATION 2016-17				Grade	Teacher
Child's name	Last	First	Middle	Birthdate	Name (Nickname) Used
Mom's email: _____			Dad's email: _____		
<input type="checkbox"/> Okay to give out email address					
Parent/Guardian Information					
Mr/Dr _____			Mrs/Ms/Dr _____		
Employer _____			Employer _____		
Work phone () -			Work phone () -		
Cell phone () -			Cell phone () -		
Home phone # () -					
Street address		City, State		Zip Code	
Co-Custodial/Non-Custodial Information					
Mr/Dr _____			Mrs/Ms/Dr _____		
Employer _____			Employer _____		
Work phone () -			Work phone () -		
Cell phone () -			Cell phone () -		
Home phone () -			Home phone () -		
Street address		City, State		Zip Code	
Emergency Contact Numbers (must have address & phone numbers)					
Name		Address		Telephone number	
Name	Relationship			Home	() -
				Cell	() -
Name	Relationship			Home	() -
				Cell	() -
Name	Relationship			Home	() -
				Cell	() -
<i>Out of State Family Member</i>				Home	() -
Name	Relationship			Cell	() -
Persons Authorized to Pick Up Child from School/KKC (must have address & phone number)					
Name	Relationship			Home	() -
				Cell	() -
Name	Relationship			Home	() -
				Cell	() -
Name	Relationship			Home	() -
				Cell	() -
Siblings attending King's Schools					
Name		Grade		Name	
Name		Grade		Name	
Who does NOT have permission to pick up your child (A copy of supporting court document must be on file.)					
Name		Reason			
Name		Reason			
Parent/Guardian Signature		Relationship		Date	

Please complete Health & Medical Information on the back.

Child's Health Information

Date of child's last physical exam	Child's Healthcare Provider	Telephone number () -
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Address	City, State	Zip Code
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Child's Dentist's Name	Telephone number () -
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Address	City, State	Zip Code
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***If any allergies or asthma, an *Individualized Plan signed by doctor must accompany
*Medication to Administer Form.**

*Special health problems? Yes or No? If yes, specify:	*Allergies, include drug reactions? Yes or No? If yes, specify:
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*Regular Medications? Yes or No? If yes, please specify:	Other important information? Yes or No? If yes, specify:
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Child's Medical Insurance Coverage

Insurance company name	Member/Policy number
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Policy holder name	Employer name
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Insurance company name	Member/Policy Name
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Policy holder name	Employer name
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Consent to Medical Care and Treatment of Minor Child

I give permission that my child, _____, may be given first aid/emergency treatment by King's Elementary School and King's Kids Club located at 19531 Dayton Ave N. Shoreline, WA 98133.

Parent/guardian Signature	Date	Parent/guardian Signature	Date
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When I cannot be contacted, I authorize and consent to medical, surgical, and hospital care, treatment, and procedures to be performed for my child by a licensed physician, healthcare provider, hospital or aid care attendant when deemed necessary or advisable by the physician or aid care attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent/guardian Signature	Date	Parent/guardian Signature	Date
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CONFIDENTIALITY WILL BE HONORED!

Thank you for assisting us in providing the best care for your child.