CASTLE ROCK SCHOOL DISTRICT
EMERGENCY INFORMATION CARD

STUDENT NAME _____ DATE OF BIRTH _____

HOME ADDRESS _____

PARENT OR GUARDIAN _____ PHONE _____

PHYSICIAN _____ PHONE _____

EMERGENCY NAME _____ PHONE _____

INSURANCE _____ PHONE _____

- MEDICATIONS _____
- ALLERGIES _____
- MEDICAL HISTORY _____

_____

_____

_____

(IMPORTANT: PLEASE COMPLETE OTHER SIDE.)

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_____

_____

_____

(IMPORTANT: PLEASE COMPLETE OTHER SIDE.)

The undersigned hereby authorizes Castle Rock Middle School as our agent to give consent to surgical or medical treatment by any licensed physician or hospital in the state of Washington for our child _____when such treatment is deemed necessary by such physicians and we cannot be reached within a reasonable length of time by reason of absence from the community or otherwise.

Such consent may include but is not limited to administration of necessary anesthetics, medical treatment, tests, x-ray, examination, transfusions, injections or drugs, and the performing of whatever operation may be deemed necessary or advisable. It is understood this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required.

_____ _____

Date Parent/Guardian

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_____ _____

Date Parent/Guardian