WELLPINIT SCHOOL DISTRICT – EMERGENCY HEALTH CARD

Student's Full Name:_____ Birth Date:_____

Address:_____ Date of Last Tetanus:_____

Allergies (Drugs, Food, Bees):_____ No Allergies_____

Present Medications_____

Medical Insurance Through_____

Dental Insurance Through_____

Other Special Instructions:_____

Physician_____ Address_____ Phone_____

Dentist _____ Address_____ Phone_____

Your Home Telephone:_____ Cell Phone Number :_____

Telephone: Father Home # Father Business # Mother Home # Mother Business #

_____ _____ _____ _____

We, the undersigned (parents or legal guardian), having legal custody of_____ minor, in our absence, do hereby authorize any x-ray examination, anesthesia, medial or surgical diagnosis or treatment and hospital service that may be rendered to the minor under general or special instructions of the family physician named above, whether such diagnosis and/or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage said physician to exercise his/her best diagnosis or treatment being required, and is given to encourage said physician to exercise his/her best judgment as requirements of such diagnosis or treatment.
This consent shall remain effective until (month/day/year)_____.

_____ _____ _____

Date Father Signature Mother Signature

_____ _____

Legal Guardian Legal Guardian