Weldon City Schools
301 Mulberry Street
Weldon, North Carolina
Phone 252/536-4821 Fax: 252/536-3062

School Emergency Card

School: WEGA WMS WSHSA RVEC

Student Name: ____ Date: _________________

Grade: _______________ DOB: ______________ Home Phone: ____________________

Address: ____ Cell Phone: ________________

Teacher/Homeroom: ___________________________________ Bus Number: ____________

Where can parents be reached if not at home: _______________________________________

Mother's Name: _________________________________ Work Phone: __________________
Cell Phone: __________________
Text: Yes [ ] No [ ]

Fathers Name: _________________________________ Work Phone: __________________
Cell Phone: __________________
Text: Yes [ ] No [ ]

List two (2) individuals who can assume temporary care of your child if you cannot be reached.

1. Name: ________________________________ Phone Number: ______________________

   Address: ____

2. Name: ________________________________ Phone Number: ______________________

   Address: ____

In case of a medical emergency, injury or serious illness, I hereby authorize school personnel to take or send my child to the family physician, urgent care, or hospital. I understand that I, the parent/legal guardian, am responsible for the cost of any and all treatment(s) provided by the treating facility.

Parent Signature: ____ Date: _________________

Physician Name: ______________________________________ Phone: __________________
Hospital Preference: ____
Serious Health Condition(s): ____
List any medications taken daily or medications needed in a medical emergency:
____

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Dear Parents,

The following is a brief health form which must be returned to the school nurse as soon as possible. This information will be reviewed by the school nurse and used to meet your child's health needs at school and PE. Please use a pen and write firmly.

School: ________________________ Homeroom Teacher: _______________________ Grade: ____

Student Name: _____________________________ DOB: _______________ Phone: ______________

Name of Dentist: _______________________________________ Phone: _________________

Does your child have health insurance? Yes [ ] No [ ]

Is your child on a special diet? Yes [ ] No [ ]

Does your child take regular medications? Yes [ ] No [ ]

Is your child able to participate in PE? Yes [ ] No [ ]

If no explain: ____
____

Has your child experienced a head injury (concussion) of any kind in the last year? Yes [ ] No [ ]

Check condition(s) your child has:

Asthma [ ] ADD/ADHD [ ] Bone/Muscle Problems [ ] Cancer/Leukemia [ ] Cardiac/Heart Problem [ ] Concussion/head injury [ ] Convulsions/seizures [ ] Cystic Fibrosis [ ]	Cerebral Palsy [ ] Dizziness/Fainting [ ] Diabetes [ ] Dietary Restrictions [ ] Emotional/Behavioral [ ] Gastrointestinal Disorders [ ] Hemophilia [ ]	High Blood Pressure [ ] Hearing Problems [ ] Nosebleeds [ ] Physical Disability [ ] POTS Severe Allergies [ ] Sickle Cell Anemia [ ] Skin Problems [ ]	Speech Problems [ ] Kidney/Bladder [ ] Vision Problems [ ] Weight Problem [ ] Other ___________ _________________ _________________

For those illnesses or developmental problems checked above, please provide additional information for each condition and contact the school nurse to receive additional paperwork that the physician will need to complete.

If your child needs medication, a special diet, or PE restrictions at school, please contact the school nurse for additional forms to be signed by the physician.

I give permission for routine health screenings to be performed by nursing staff and outside affiliates to include (Height, Weight, Vision, Hearing, & Dental). I understand that I will be notified of any possible problems detected.

Parent/Guardian Signature: ____ Date: __________