WOODDALE ACADEMY

5532 Wooddale Avenue South, Edina, MN 55424
P: (952) 656-1055

WOODDALE ACADEMY, EDINA
CHILD "EMERGENCY" INFORMATION

CHILD'S NAME _____ BIRTH DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PREFERRED PHONE _____ PREFERRED EMAIL _____

INSURANCE INFORMATION: DO NOT HAVE HEALTH INSURANCE: ☐ Yes ☐ No

HEALTH INSURANCE POLICY NAME _____ I.D. # _____ GROUP # _____

PRIMARY SUBSCRIBER'S NAME _____ EMPLOYER _____

MOTHER _____ HOME PHONE _____ CELL PHONE _____

OCCUPATION _____ EMPLOYER _____ WORK PHONE _____

PREFERRED EMAIL _____

FATHER _____ HOME PHONE _____ CELL PHONE _____

OCCUPATION _____ EMPLOYER _____ WORK PHONE _____

PREFERRED EMAIL _____

EMERGENCY CONTACTS: THE FOLLOWING PEOPLE ARE AUTHORIZED TO BE CONTACTED IN CASE OF EMERGENCY. THESE INDIVIDUALS HAVE ACCESS TO HEALTH INFORMATION ABOUT MY CHILD & ARE AUTHORIZED TO MAKE DECISIONS IN MY ABSENCE.

EMERGENCY CONTACT #1: _____ ADDRESS _____

PHONE: _____ HOME _____ CELL _____ WORK

EMERGENCY CONTACT #2: _____ ADDRESS _____

PHONE: _____ HOME _____ CELL _____ WORK

IMMUNIZATIONS: DATE OF LAST DOSE: -_____ DTAP _____ HIB _____ IPV _____ MMR _____ CHICKEN POX

MEDICAL HISTORY: PLEASE LIST FACTS CONCERNING YOUR CHILD'S MEDICAL HISTORY INCLUDING **ASTHMA**, **ALLERGIES**, **CHRONIC ILLNESS**; **MEDICATIONS** , OR ANY **PHYSICAL IMPAIRMENTS** WHICH MEDICAL PERSONNEL SHOULD BE AWARE:

_____

_____

PLEASE COMPLETE REVERSE SIDE

CHILD'S DENTIST _____ ADDRESS _____

CLINIC PHONE _____

CHILD'S PHYSICIAN _____ ADDRESS _____

CLINIC PHONE _____ HOSPITAL PREFERENCE _____

CONSENT FOR EMERGENCY TREATMENT: I GRANT MY AUTHORIZATION AND CONSENT FOR WOODDALE ACADEMY STAFF to view my child's health information on file and administer general first aid treatment for any minor injuries or illnesses experienced by the minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize Wooddale Academy Staff to summon any and all professional emergency personnel to attend, transport, and treat the and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state of MN. It is understood that this authorization is given in advance of any such medical treatment to provide authority and power on the part Wooddale Academy Staff to exercise their best judgment upon the advice of any such medical or emergency personnel. I understand I am financially responsible for all expenses incurred to provide emergency treatment for my child.

Below are people authorized to pick up my child from Wooddale Academy

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

SIGNATURE OF "LEGAL" PARENT OR GUARDIAN: _____ DATE _____

PLEASE INITIAL IF INFORMATION BEEN UPDATED: _____ AUG _____ NOV _____ FEB _____ MAY

A NEW EMERGENCY FORM MUST BE COMPLETED EACH SCHOOL YEAR

PLEASE RETURN FORM TO:

WOODDALE ACADEMY, EDINA

EMAIL: EDINA.ACADEMY@WOODDALE.ORG

FAX: 952-777-4211