2019-2020

WHITE MEMORIAL ADVENTIST SCHOOL

EMERGENCY CONSENT FORM

IF WE ARE UNABLE TO REACH YOU IN THE EVENT OF A MAJOR EARTHQUAKE OR OTHER DISASTER THE FOLLOWING INFORMATION WILL BE USED:

WE, THE PARENTS OF _____GIVE PERMISSION FOR OUR CHILD TO BE RELEASED TO: *(MUST HAVE AT LEAST 3 CONTACTS).*

THREE (3) CONTACTS WITH 3 DIFFERENT NUMBERS IS REQUIRED!

1. NAME _____ RELATIONSHIP TO STUDENT: _____

CELL PHONE NUMBER _____ALTERNATE NUMBER:_____

2. NAME _____ RELATIONSHIP TO STUDENT: _____

CELL PHONE NUMBER _____ALTERNATE NUMBER:_____

3. NAME _____ RELATIONSHIP TO STUDENT: _____

CELL PHONE NUMBER _____ALTERNATE NUMBER:_____

IN THE EVENT THAT NONE OF THE ABOVE–NAMED INDIVIDUALS IS AVAILABLE PLEASE:

____ RELEASE MY CHILD TO ANY ADULT WHOM HE/SHE RECOGNIZES FAVORABLY

____ DO NOT RELEASE MY CHILD TO ANYONE NOT NAMED ABOVE

I UNDERSTAND THAT IF NO RECOGNIZABLE ADULTS ARE AVAILABLE AND THAT IF SAFETY REQUIRES IT, MY CHILD MAY BE TRANPORTED BY WHITE MEMORIAL ADVENTIST SCHOOL TO A CENTRAL LOCATION DESIGNATED BY THE SCHOOL. IN CASE OF DOUBT, THE STAFF RESERVES THE RIGHT TO REFUSE RELEASING THE CHILD TO ANYONE OTHER THAN A PARENT.

AFTER SCHOOL MY CHILD IS TO: *(CHANGES WILL NOT BE ALLOWED WITHOUT WRITTEN NOTICE BY PARENT)*

____ WALK HOME *Permission to walk home alone is attached* ____ GO TO DAYCARE ____ GO HOME WITH: _____

AS STATED IN THE HANDBOOK: "ALL STUDENTS MUST BE SUPERVISED BY AN ADULT AFTER SCHOOL AS REQUIRED BY OUR SCHOOL INSURANCE POLICY. **ANYONE ON CAMPUS ONE–HALF HOUR AFTER DISMISSAL TIME IS REQUIRED TO SIGN INTO DAYCARE.** LOITERING AT THE SCHOOL, ON THE STREET, IN THE PARKING LOTS OR IN OTHER UNSUPERVISED AREAS IS NOT ALLOWED. FINES AND DISCIPLINARY ACTION WILL BE IMPOSED ON STUDENTS NOT COMPLYING WITH THESE GUIDELINES."

UNDER NO CIRCUMSTANCE IS MY CHILD TO BE RELEASE TO THE FOLLOWING PERSON/S:

NAME _____REASON: _____

DESCRIBE ALL MEDICAL CONDITIONS/ALLERGIES AND TREATMENT (IE: MEDICATION)

1._____TREATMENT _____

2._____TREATMENT _____

DATE OF LAST TETANUS (DTP/DT) SHOT — AS LISTED ON THE YELLOW IMMUNIZATION CARD

MONTH_____ DAY_____YEAR _____

LOCAL FAMILY PHYSICIAN/S TO BE CALLED IN CASE YOUR SON OR DAUGHTER BECOMES ILL OR HAS AN ACCIDENT AND YOU CANNOT BE REACHED

1. FAMILY PHYSICIAN_____ OFFICE TELEPHONE _____

IF EMERGENCY SERVICE INVOLVING MEDICAL ACTION OR TREATMENT IS REQUIRED AND NEITHER THE PARENT NOR THE FAMILY PHYSICIAN CAN BE REACHED FOR CONSENT, THE PARENTS HEREBY CONSENT TO THE RENDERING OF SUCH EMERGENCY MEDICAL SERVICE FOR THE ABOVE NAMED STUDENT AS SHALL BE NECESSARY IN THE OPINION OF THE DOCTOR RENDERING THE SERVICE. THIS AUTHORIZATION IS GIVEN PURSUANT TO THE LOCAL STATE CIVIL CODE.

SIGNATURE OF PARENT/GUARDIAN _____**DATE**_____