Student Name — Last, First

West Cobb Christian Academy

2010 – 2011 Emergency Information Form

Student Information

Legal Name _____
First Middle Last Suffix Nickname

Address _____ Gender: ❑ Male ❑ Female

_____ Date of Birth: _____

Home Phone _____ Social Security Number: _____

Parent/Legal Guardian Information

First Name _____ Last Name _____ Relation _____
Home Phone _____ Mobile Phone _____ Work Phone _____
Driver's License: State _____ Number _____

First Name _____ Last Name _____ Relation _____
Home Phone _____ Mobile Phone _____ Work Phone _____
Driver's License: State _____ Number _____

Insurance Information *(please attach a front and back copy of your insurance card, notifiy the school immediatly of any changes in insurance)*

Primary Insurance Carrier _____
Policy Holder's Name _____ Employer _____
Member ID Number _____ Group/Policy Number _____
Billing Address _____

Medical Information *(use back of form if additional space is needed)*

Primary Physician's Name _____ Office's Name _____
Address _____ Office Phone _____
Known Allergies: _____
Known Medical Conditions: _____
Special Dietary Needs: _____
Other Conditions / Concerns: _____
Date of Last Tetanus: _____

Additional Emergency Contacts

First Name _____ Last Name _____ Relation _____
Home Phone _____ Mobile Phone _____ Work Phone _____

First Name _____ Last Name _____ Relation _____
Home Phone _____ Mobile Phone _____ Work Phone _____

Statement of Consent *(to be signed in the presence of a legalized notary public)*

In the event of an emergency or non-emergency situation requiring medical treatment, I, the parent/guardian listed below, hereby grant permission for any and all medical and/or dental attention to be administered to my child, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, transport of my child to a medical facility, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

_____ _____ _____
PARENT/GUARDIAN PRINTED NAME SIGNATURE DATE

Notarization

State of Georgia, County of _____.
Subscribed and sworn to before me this _____ day of _____ 20___.

Notary Signature: _____ Comission Expires: _____ Seal:

2732 Macland Road • Marietta, GA 30064 • 770-359-8754 • info@westcobbchristian.org • www.westcobbchristian.org