

**2019-2020**  
**Waldorf High School of Massachusetts Bay**  
**Emergency Sheet**

Date: \_\_\_\_\_

Student's name: \_\_\_\_\_

Birth date: \_\_\_\_\_ Grade: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary phone # for school messages i.e. snow days:  
\_\_\_\_\_

Parent home phone: \_\_\_\_\_

Parent home e-mail address:  
\_\_\_\_\_

Student cell phone: \_\_\_\_\_

Student E-Mail address: \_\_\_\_\_

**Medical Information**

**Student's Doctor:** \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Student medical information (physical or emotional), i.e. allergies, etc.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications student takes:  
\_\_\_\_\_  
\_\_\_\_\_

**No over-the-counter medications will be administered without a Parent/Guardian Medication Consent Form, including Tylenol or Advil. Also required for prescription medications (see below).**

I have attached a completed Parent/Guardian Medication Consent Form.

**No prescription medications will be administered without a Licensed Prescriber Medication Order Form along with the Parent/Guardian Medication Consent Form.**

I have attached a completed Licensed Prescriber Medication Order Form.

I have attached a completed Parent/Guardian Medication Consent Form.

**Mother/Guardian's name & daytime information:**

Where parents/caregivers can be reached during the day in case of emergency:

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**Father/Guardian's name & daytime information:**

Where parents/caregivers can be reached during the day in case of emergency:

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**TURN OVER TO COMPLETE FORM**

Please provide two alternate names of people who could care for your child in case of illness or accident:

**Name #1:** \_\_\_\_\_

Relationship: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Day time phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

**Name #2:** \_\_\_\_\_

Relationship: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Day time phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

IN CASE OF MEDICAL EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY WALDORF HIGH SCHOOL OF MASSACHUSETTS BAY TO SECURE PROPER TREATMENT FOR MY CHILD,

**X** \_\_\_\_\_  
Signature of parent or guardian:

I ALSO GIVE PERMISSION FOR MY CHILD TO BE TREATED AT THE NEAREST FACILITY (MT. AUBURN HOSPITAL) OR OTHER HOSPITAL SELECTED BY THE BELMONT FIRE DEPARTMENT PERSUANT TO THE INJURY.

**X** \_\_\_\_\_  
Signature of parent or guardian:

Date: \_\_\_\_\_

Insurance plan under which student is covered:

Insurance Company: \_\_\_\_\_

Type of plan: \_\_\_\_\_

Certificate #: \_\_\_\_\_

Subscriber: \_\_\_\_\_

**Note:** *It is understood that Waldorf High School of Massachusetts Bay will attempt to contact parents immediately in the event of an emergency. The above release statement will enable the school to secure medical/surgical care for your child should the school be unable to reach you.*