Klickitat School District

2021 - 2022 STUDENT OFFICE CARD

STUDENT NAME: Legal Last Name	Legal First Name	Legal Middle Name	Also known as:
BIRTHDATE (Month/Day/Year)	GENDER (circle one) Male Female X	GRADE	Are any parents/guardians Active Duty US Military? Yes-Branch_____ NO
Birth Place: (city)	(state)	(Country)	(County)

PRIMARY HOUSEHOLD (parent/guardian where student lives) — Ethnicity:

PARENT/GUARDIAN NAME Last Name First Name	Relationship to Student	PHONE #1 Home Work Cell (circle one) ( ) -	PHONE #2 Home Work Cell (circle one) ( ) -
PARENT/GUARDIAN NAME Last Name First Name	Relationship to Student	PHONE #1 Home Work Cell (circle one) ( ) -	PHONE #2 Home Work Cell (circle one) ( ) -

HOME ADDRESS (PHYSICAL ADDRESS)	CITY	STATE	ZIP CODE
MAILING ADDRESS (if different from above)	CITY	STATE	ZIP CODE
	email :		

SECONDARY HOUSEHOLD (non-cusotidal parent/guardian not living with student)

NON-CUSTODIAL PARENT/GUARDIAN Last Name First Name	Relationship to Student	PHONE #1 Home Work Cell (circle one) ( ) -	PHONE #2 Home Work Cell (circle one) ( ) -
SECOND HOUSEHOLD MAILING ADDRESS	(Street/PO Box, City, State ZIP)		Additional Mailings? Yes No (please circle)

CHILD CARE INFORMATION

(Circle one) Child: Does not attend child care Attends before school Attends after school Attends before & after school

CARE GIVER'S NAME Last Name First Name	STREET ADDRESS CITY	PHONE NUMBER ( ) -

EMERGENCY CONTACT INFORMATION

STUDENT RELEASE AUTHORIZATION

When injury, illness or other non-emergency situations occur involving your child, we want to be able to quickly reach families or other responsible adults. In the event we cannot reach a parent/guardian, please list persons who you trust who are available during the day to provide care for your child.

PRIMARY CONTACT (other than parent/guardian) Last name First name	Relationship to Child	PHONE #1 Home Work Cell (circle one) ( ) -	PHONE #2 Home Work Cell (circle one) ( ) -
PRIMARY CONTACT ADDRESS		CITY	STATE ZIP CODE

SECONDARY CONTACT (other than parent/guardian) Last name First name	Relationship to Child	PHONE #1 Home Work Cell (circle one) ( ) -	PHONE #2 Home Work Cell (circle one) ( ) -
SECONDARY CONTACT ADDRESS		CITY	STATE ZIP CODE

STUDENT RELEASE AUTHORIZATION: In the event that the school is unable to contact the parent/guardian, I authorize that my child may be released to the person(s) listed above.

Legal Parent/Guardian Signature _____ Date _____

If none of the above can be contacted, what do wish the school to do if your child is sick or injured:

Although the above recommendation of the parent will be respected insofar as possible, I understand that in the final disposition of an emergency case the judgment of the school authorities will prevail.

Anytime the above information needs to be changed, please provide notification of changes to the school district office in writing.

***** Please complete the "Authorization for Medical Treatment Form" that is on the reverse side.***

OFFICE USE ONLY

COMMENTS	ADMISSION INFORMATION Date _____ Grade _____ From	STUDENT ALLERGIES/MEDICAL ALERT

STUDENT HEALTH REGISTRATION FORM & CONSENT FOR EMERGENCY MEDICAL TREATMENT 2021-2022

Student Name: _____ Date of Birth: _____ Grade: _____ Gender: _____
Physical address: _____
Mailing address (if different): _____

Father's Name: _____ Cell Phone: _____ Email: _____
Father's mailing address (if different): _____
Father's Employer: _____ Work phone: _____

Mother's Name: _____ Cell Phone: _____ Email: _____
Mother's mailing address (if different): _____
Mother's Employer: _____ Work phone: _____

Emergency Contact: _____ Relationship: _____ Phone number: _____
Emergency Contact: _____ Relationship: _____ Phone number: _____

Doctor: _____ Phone: _____ Dentist: _____ Phone: _____
Preferred Hospital: _____ Medical insurance: _____ Policy #: _____

PLEASE CIRCLE ANY LIFE-THREATENING CONDITIONS

State Law, RCW 28A.210 requires that students with life-threatening health conditions must have physician orders and a nursing care plan before attending school. This information may be shared with school district staff that have a "need to know," in order to provide a healthy, safe environment.

☐ NO KNOWN HEALTH CONCERNS	
RESPIRATORY PROBLEMS: Asthma, cystic fibrosis, etc.	Severity: Special needs/medications:
SEVERE ALLERGY TO: Food, insects, medication Life-threatening: ☐ Yes ☐ No	Allergen/ reaction: Medications needed:
SEIZURE DISORDER: Epilepsy etc.	Type: Special needs/medications:
A.D.D./ A.D.H.D (circle one)	Special needs/medications:
DIABETES	Type: Special needs/medications:
NEUROLOGICAL CONDITION: Hydrocephalus, cerebral palsy, etc.	Type: Medication needed:
HEART CONDITIONS	Type: Special needs:
ORTHOPEDIC PROBLEMS: Arthritis, scoliosis, braces, wheelchair	Type: Surgeries/limitations:
CANCER, LEUKEMIA, TUMORS	Type: Special needs/medications:
DIGESTIVE PROLEMS: Ulcers, colitis, etc.	Type: Special needs/medications:
URINARY/KIDNEY DISORDER	Type: Special needs/medications:
VISION/HEARING PROBLEMS OR COMPLETE LOSS OF	Type: Special needs/contacts/glasses/hearing aids
SERIOUS ILLNESS, INJURIES, OPERATIONS	Type: Special needs:
OTHER DIAGNOSED HEALTH PROBLEMS	Type: Special needs:

IF MEDICATIONS ARE NEEDED AT SCHOOL PLEASE CONTACT THE SCHOOL OFFICE FOR APPROPRIATE FORMS

I will keep the school health services informed throughout the year regarding any changes in health status and/or contact information. I understand that if either parent/guardian or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize the school staff to request emergency medical services (911). I understand I may be responsible for the payment of any medical services if needed.

Parent/guardian signature: _____ Date: _____