



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

**Please mark and answer all applicable questions below.**

1. Does this student receive Special Education Services? \_\_\_\_\_
2. Does this student live outside of the USD#292 School District? \_\_\_\_\_
3. Is this student a bus Rider? \_\_\_\_\_ To and from what address? \_\_\_\_\_
4. Does this student have a parent actively in the military? \_\_\_\_\_
5. What was your student's original date of enrollment into a state of Kansas school? (Can be an approx. date.) \_\_\_\_\_

**Please list all children in the household who are 5 years of age and under.**

Name	Birth Date	Name	Birth Date
_____	_____	_____	_____
_____	_____	_____	_____

**Emergency Information**

**In case of emergency, we will attempt to contact parent/guardian first. In the event we cannot do this, please provide the name of a relative or close friend that we may contact.**

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Allergies: \_\_\_\_\_

List any Medical Comments/Considerations: \_\_\_\_\_

List any Medical Alerts: \_\_\_\_\_

**Automated Phone Calling System –AlertNow**

If called of an Evening, contact at phone number #: \_\_\_\_\_

If called before school, contact Mother at phone# \_\_\_\_\_ /contact Father at phone # \_\_\_\_\_

**Consent to Participate in Field Trip or Other Activity and Consent for Treatment**

I, the parent and legal guardian of \_\_\_\_\_, give my consent for my child to participate in field trips/other activities taken by Wheatland High School during the 2010-2011 . I further give my legal consent and authorize any representative of Wheatland High School to authorize emergency medical treatment, including any necessary surgery or hospitalization, for my above-named child, for any injury or illness of an emergency nature he/she incurred while participating in the field trip or other activity noted above by any physician or dentist licensed in accordance with the provisions of the Kansas Healing Arts Act, K.S.A. 65-2801, and any hospital.

I agree to pay and assume all responsibility for medical and hospital expenses and any emergency services incurred on behalf of my child.

I acknowledge and agree that Wheatland High School is not responsible for any medical, hospital expenses and/or other charges that are incurred in the medical treatment or hospitalization of my child. A photocopy of this document shall have the same force and effect as the original. If my child requires emergency medical treatment, I understand that school personnel will make a reasonable attempt to contact me to seek my permission to authorize that treatment. To facilitate contacting me, I agree to continue to provide current work and home phone numbers to the school.

\_\_\_\_\_  
Legal Parent/Guardian Signature

\_\_\_\_\_  
Date