Windsor Learning Center
Emergency Reference Information
2023-2024

Student's Name: _____ Gender: _____ Home Phone: _____

Street Address: _____ Date of Birth: _____

_____
City State Zip Code

Guardian: _____ Work Phone: _____ Cell Phone: _____

Guardian: _____ Work Phone: _____ Cell Phone: _____

Please list TWO neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Physician's Name: _____ Phone: _____

In the event of an extreme emergency, if parent, guardian, or emergency numbers listest cannot be reached, I give my permission to the school to arrange proper medical care at the nearest hospital or any other necessary medical or dental facility.

Signature of Guardian: _____ Date Signed: _____

IMPORTANT: All medications, for students under the age of 18, must be delivered to and from school in the original container.

Name and dosage of medication your student must take during school hours (if none, please write "none"):

_____

Name and dosage of medication taken at home (if none, please write "none"):

_____

Allergies (if none, please write "none"): _____

Type: _____

Symptoms: _____

Medication: _____

The School Nurse, at the the nurse's discretion and supplied by the school, hereby has my permission to dispense (in age/weight appropriate dosage) the following medications:

☐ Antacid Tablet (for stomach)	☐ Yes	☐ No
☐ Acetaminophen (Tylenol)	☐ Yes	☐ No
☐ Ibuprofen (Advil/Motrin)	☐ Yes	☐ No
☐ Cough Drip	☐ Yes	☐ No

I hereby authorize the release of pertinent medical information (medical conditions, allergies, and/or medical regimens) to be exchanged among appropriate professional staff involved in the care of my student.

Signature of Guardian: _____ Date Signed: _____