THE WOLF SCHOOL
EMERGENCY AUTHORIZATION FORM - 2016-2017

Child's Name:_____ Date of Birth:_____

Parent #1 Name:_____

Home Address:_____

Home Phone #:_____ Work Phone #:_____ Cell Phone #:_____

Home E-Mail:_____ Work E-Mail:_____

Place of Employment: _____

Parent #2 Name:_____

Home Address (if different from above):_____

Home Phone#:_____ Work Phone#:_____ Cell Phone #:_____

Home E-Mail:_____ Work E-Mail:_____

Place of Employment: _____

List two (2) relatives/friends, within a 50-mile radius of The Wolf School, who can be contacted in an emergency:

1._____ Phone #_____

2._____ Phone #_____

Child's Allergies (PLEASE BE SPECIFIC)_____

My child is able to participate in all school and athletic activities. Yes ( ) No ( ) If no, please specify restrictions via the State of Rhode Island Physical Form.

State of Rhode Island requires all students to have annual dental and eye exams. Please indicate dates examinations occurred.

Date of Eye Exam_____ Date of Last Dental Exam_____

Health Insurance:_____ Health Insurance ID#: _____

Primary Care Physician's Name:_____

Address & Phone #:_____

In the event of a health emergency, the Wolf School will make every effort to contact parents or the person(s) indicated. However, if we are unable to reach any of the above, you must sign below giving your permission for Wolf School personnel to take such action as they deem necessary.

Parent's Signature:_____ Date:_____