STUDENT EMERGENCY CONTACT CARD

Emergency Contacts / Medical Consent (other side)

Office Use Only

CSIS #

Date Enrolled

❒ MEDICAL
❒ CUSTODY
❒ SPECIAL NEEDS

In case of an emergency, it is imperative that the school be able to reach the student's parent or guardian. Please fill in the information on both sides of this card carefully and accurately. Please type or use ink and print clearly and legibly. GRADE _____

STUDENT _____ Male / Female _____

Last Name First Middle Homeroom Teacher

_____ _____ _____

Home Address (Primary Residence) City Zip Code Birthplace Birthdate

1. _____ **2.** _____

Mandatory Email Address for School Info/Contact Only ☐ **Check if no email access**

Lives with: ❑ Both Parents ❑ Mother ❑ Father ❑ Legal Guardian

Address change? ❑ No ❑ Yes If Yes, please contact the School Office.

MOTHER/GUARDIAN _____ _____ | _____

Last Name First Home Phone Cell Phone

_____ _____ | _____

Home Address for mother, if different from above City Zip Code Work Phone Employer

FATHER/GUARDIAN _____ _____ | _____

Last Name First Home Phone Cell Phone

_____ _____ | _____

Home Address for father, if different from above City Zip Code Work Phone Employer

Are there any COURT-MANDATED custody/visitation orders limiting access to this student? ❑ **No** ❑ **Yes** ➡ **If Yes, please attach LEGAL ORDER.**

Other children at home: _____ | ___ | _____ _____ | ___ | _____

Name Grade School Name Grade School

Languages spoken at home: 1. _____ 2. _____

AUTHORIZED CONTACTS Please list 3 names of relatives/neighbors/siblings 18+ in close proximity to the school to whom we may release your child or contact if you cannot be reached. **NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PARENTS, GUARDIANS OR ADULTS LISTED ON THIS CARD.**

In selecting someone to whom you authorize the release of your child, consider: (a) Would your child feel safe and comfortable with this person and family? (b) Could this person care for your child for several days? (c) Is this person prepared to handle any special medical needs required by your child?

I/we hereby authorize the release of the student named above to the following persons in the event of illness, injury, evacuation, or emergency that may occur while students are in school. These contacts will also be notified in an emergency via the district's Connect-ED system.

Name	Relationship	Home Phone	Work/Cell Phone (specify)
1.			
2.			
3.			
Out-of-state contact:			

I declare that the information on this form is true and correct. I will notify the school office immediately of any changes to above information.

Parent/Guardian Signature _____ Date _____ Relationship _____

Continued ⇨

SCHOOL YEAR 2010/11 STUDENT:

STUDENT EMERGENCY CONTACT CARD

Medical Information and Consent

STUDENT _____

Last First Middle

MEDICAL/HEALTH INFORMATION

Medication: Does your child require medication? ☐ No ☐ Yes

➨ If your child requires medication at school, all medication sent to school must be in the original prescription container with a current date and the child's name. An "Authorization for Administration of Medication" form must be on file. For disasters, please provide a separate three-day supply for the school office, in the same format, with the along with the green "72-Hour Disaster Medication" form. Both forms are available from the school office.

Medication	Dosage	Hour(s) given

Health Insurance Information: *Please check appropriate box.*

❑ Family Health Insurance □ ❑ Healthy Families □ ❑ California Kids □

❑ Medi-Cal □ # _____ ❑ No Health Insurance □

Physician/Health Care Provider_____ Phone No. _____

Health Plan/Group Name _____ Policy No. _____

Dentist _____ Phone No. _____

Vision and/or Hearing Problems:

❑ Wears glasses/contacts: ➨ ❑ for board work □ ❑ for reading □ ❑ all the time □

Date of last eye exam _____ ❑ Wears hearing aid(s) □

Medical Conditions: Please check the appropriate boxes if your child has any of the following:

□❑ Severe allergies requiring: ➨ ❑ Epi-pen □ ❑ Benadryl □

❑ Food/Environmental □ ❑ Stinging Insects/Bees □ ❑ Medicines/Drugs □ ❑ Other □

Please explain: _____

□❑ Current asthma If checked, ➨ ❑ uses inhaler ❑ on daily medication

□❑ Current seizures If checked, on medication? ➨ ❑ Yes □ ❑ No □

□❑ Diabetes If checked, insulin dependent? ➨ ❑ Yes □ ❑ No □

□❑ Behavior problems: _____

□❑ Movement limitations: __-

_____

□❑ Other (please explain): __-

_____

□❑ Recent illness, hospitalization or surgery. If checked, please provide date(s) and description(s):

_____

We recommend that you duplicate this card for your records.

EMERGENCY TREATMENT AUTHORIZATION

I/we, the undersigned parent(s) or legal guardian of _____, a minor, do hereby give authorization and consent to the school to obtain emergency medical care and necessary transportation, including x-ray examination, anesthetic, medical or surgical diagnosis and emergency hospital which is deemed advisable by and is to be rendered under the general or specific supervision of medical and emergency room staff licensed under the provisions of the medicine practice act and the State of California Department of Public Health.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the student, but that any of the above treatment will not be withheld if the undersigned or authorized adults cannot be reached.

_____ *is the hospital I/we prefer for emergency medical treatment of my/our child.*

I/we understand that the school district does not provide accident/medical insurance for students, and I/we further understand that all costs related to medical treatment may be my/our responsibility and not that of the school district.

_____ _____

Parent/Guardian Signature Date

VOLUNTEER ASSISTANCE

If you live close to school and feel that, if called, you can offer volunteer assistance during an emergency, please provide your name, phone number and expertise.

I would like to help in an emergency.

_____ _____

Name Phone

_____

Qualifications

2/10