



# STUDENT EMERGENCY CONTACT CARD

Emergency Contacts / Medical Consent (other side)

Office Use Only

- 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.

## STUDENT

|           |       |        |
|-----------|-------|--------|
|           |       |        |
| Last Name | First | Middle |

Male  Female Grade

Home Address (Primary Residence) City State/Zip

Mailing Address, if different from above City State/Zip

## MOTHER/GUARDIAN

|           |       |        |
|-----------|-------|--------|
|           |       |        |
| Last Name | First | Middle |

Home Address, if different from above City State/Zip

## FATHER/GUARDIAN

|           |       |        |
|-----------|-------|--------|
|           |       |        |
| Last Name | First | Middle |

Home Address, if different from above City State/Zip

## AUTHORIZED CONTACTS

Please list the names of relatives/ neighbor/friends in close proximity to the school to whom we may release your child or contact

if you cannot be reached. Please list names in order of who to call first, second and third. **NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PARENTS, GUARDIANS OR ADULTS LISTED ON THIS CARD.**

*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.*

| Name                  | Relationship | Home Phone | Work or Cell Phone |
|-----------------------|--------------|------------|--------------------|
|                       |              |            |                    |
|                       |              |            |                    |
|                       |              |            |                    |
| 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 be made in the foregoing information.*

STUDENT:

SCHOOL:

Parent/Guardian Signature

Date

Relationship

# 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.

| 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 hearing aid(s)     Wears glasses/contacts:

for board work     for reading     all the time    Date of last eye exam   

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

- Food/Environmental     Stinging Insects/Bees     Medicines/Drugs     Other:
- 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. please provide date(s) and description(s):

Medical condition which might require care or accommodation at school (please describe):

### 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