**EMERGENCY INFORMATION**

**STUDENT ID#_____** **San Juan Unified School District** **GRADE _____**

**CHILD'S FULL LEGAL NAME:**

_____ ☐ Male ☐**Fem**ale

Last First Middle

Name Child uses (nickname)_____ Birthdate _____

**Parent or Guardian Information : Primary Contact Number _____**

Student Lives With: (Check One) ☐ Father Only ☐ Mothe**r** Only ☐ Both Parents ☐ Foster/Guardian

**Note: If a legal action curtails the rights of a parent/guardian, you must attach the most current copy of any stipulation or court order.**

☐ Attached ☐ Not Applicable

**Father: _____ Check one:** ☐ Natural ☐ Step ☐ Foster/Guardian ☐ Other

Home Address: _____ Home Phone _____

Employer _____Work Phone:_____Cell Phone:_____

Email _____

**Mother: _____ Check one:** ☐ Natural ☐ Step ☐ Foster/Guardian ☐ Other

Home Address: _____ Home Phone _____

Employer _____Work Phone:_____Cell Phone:_____

Email _____

If my child is ill, has an emergency, or is suspended and I cannot be reached, please call and release my child to: *(Other than listed above)*

Name:_____Home/Work Phone:_____Cell Phone:_____

Check One: ☐Relative ☐Day Care Provider ☐Friend ☐Neighbor ☐Other

Name:_____Home/Work Phone:_____Cell Phone:_____

Check One: ☐Relative ☐Day Care Provider ☐Friend ☐Neighbor ☐Other

Physician's Name:_____Medical Coverage by:_____ID#:_____

Address:_____Physician's Phone:_____Hospital Preference:_____

***Parent must check one***

☐ 1. In the event of an emergency, when a parent or guardian is unavailable, I authorize school personnel to make arrangements for my child to receive medical/hospital care, including necessary transportation, in accordance with their best judgment. I authorize the physician named above to undertake such care and treatment as considered necessary. In the event said physician is unavailable, I authorize such care and treatment to be performed by a licensed physician or surgeon. I agree to pay all costs uncured as a result of the foregoing.

☐ 2. I do not choose the above statement and desire the following action in the event of an emergency:_____

*X*_____ _____ *X*_____ _____

*Parent/Guardian Signature* *Date* *Parent/Guardian Signature* *Date*

Please complete back of form.

**PLEASE CHECK THE FOLLOWING ITEMS AS THEY PERTAIN TO YOUR CHILD**

☐ No Medical or Health Concerns

**VISION:**

☐Wears glasses ☐To be worn at all times
☐Wears contacts ☐To be worn at all times
☐Requires preferential seating

Date of Last Eye Exam:_____Comments: _____

Under care of Dr._____Phone:_____

**HEARING:**

☐Has a hearing problem☐Has tubes in ears ☐Uses hearing aid
☐Requires preferential seating

Date of Last Hearing Exam:_____Comments: _____

Under care of Dr._____Phone:_____

**HEALTH CONCERNS:**

1. Has the following condition(s):
   ☐Asthma ☐Seizures ☐Migraines ☐Diabetes
   ☐Hyperactive (ADHD) ☐Heart Condition

   Allergies (describe):_____
   Allergic reaction to bee stings (describe):_____
   Other:_____
   Are any of the above life-threatening? ☐Yes ☐No (explain):_____
2. List medication prescribed:_____
   Current dosage:_____For (diagnosis):_____
   Prescribed by Dr._____Phone:_____
   Does the drug need to be taken during school hours? ☐Yes ☐No
   "Medication in School" form on file (renew annually) ☐Yes ☐No
3. Has a physical condition which limits participation in: ☐Classroom activities ☐Physical Education
   (Please explain):_____

**PLEASE READ AND SIGN**

*"I authorize the release of my child's medical information (1) by the school district and the provider of services to the billing agent and (2) by the school district to my insurance carrier as necessary to process a claim or to request payment of Medical Assistance Benefits. Shared information will be limited to health service documentation only."*

_____ _____
*Parent/Guardian Signature* *Date*

_____ _____
*Print Name* *Relationship*