

CONFIDENTIAL

Student's Last Name (Legal)		First Name	Middle	Date of Birth		School Year _____ School _____		Office Use Only Teacher/Counselor _____ Grade _____ Room _____ Bus _____ CONCAP [] Hm. Sch. _____ Sp. Ed. [] RSP [] Eth. Cd []		
Street Address			Apt #	Zip Code		Last School of Attendance _____ City _____				
Home Phone (1): _____			Home Phone (2): _____							
Father's Name (Guardian) _____ (Soc. Sec. #) _____ Check One: Natural ____ Step ____ Guardian/Foster __ Driver's Lic. # _____				Place of Employment: _____ _____ E-mail address _____				Work Phone: _____ Cell Phone: _____ Pager: _____		
Mother's Name (Guardian) _____ (Soc. Sec. #) _____ Check One: Natural ____ Step ____ Guardian/Foster __ Driver's Lic. # _____				Place of Employment: _____ _____ E-mail address _____				Work Phone: _____ Cell Phone: _____ Pager: _____		
Day Care Provider: _____ Phone #1: _____ Phone #2: _____										
List names of other children attending this school:				School is authorized to share my phone number with the PTA: Yes _____ No _____		Check here if student will be riding the bus: Yes _____ Bus Number: _____				
Parent/Guardian with whom the child lives _____ Phone # _____ If the parents are divorced or separated, to whom has physical custody been given? (attach verification) _____										

The parent/guardian is responsible for keeping the school informed of updates or changes to the student's emergency information. The school shall be notified, in writing, of telephone or address changes within three days (3) of the occurrence. If the school is unable to reach anyone on this card in an emergency or if a student is left unattended during non-school hours, the school will contact law enforcement or Child Protective Services.

I have read this and understand my responsibility. _____ *Parent / Guardian Signature*

Name 1: _____

Phone: _____ Relationship _____

Name 3: _____

Phone: _____ Relationship _____

Name 5: _____

Phone: _____ Relationship _____

Name 7: _____

Phone: _____ Relationship _____

Name 2: _____

Phone: _____ Relationship _____

Name 4: _____

Phone: _____ Relationship _____

Name 6: _____

Phone: _____ Relationship _____

Name 8: _____

Phone: _____ Relationship _____

Special instructions / comments / (Include instructions for pickup of student):

Complete All Information on Both Sides**CONFIDENTIAL****Please Print****General Health Information**Check here if there are no known health problems. ☐ Blood type, if known _____**Eyes:** Wears glasses ☐ Glasses to be worn at all times ☐ Wears Contacts ☐ Requires preferential seating ☐

Comments: _____

Ears: Known hearing problem ☐ Uses hearing aids ☐ Has tubes in ears ☐ Requires preferential seating ☐

Comments: _____

Has the following condition(s):Epilepsy ☐ Fainting Spells ☐ Diabetes ☐ Heart Condition ☐ Asthma ☐ Attention Deficit Disorder ☐Severe bee sting allergy ☐ Describe: _____

Other: _____

Are any of the above life threatening? Yes ☐ No ☐ Please explain: _____

** Medicine prescribed on a regular basis: _____ Dosage: _____ Diagnosis: _____

*** Does the drug need to be taken during school hours? Yes ☐ No ☐ Prescribed by Dr. _____ Phone _____Has condition that limits participation in: classroom ☐ physical education ☐ Explain: _____

Under care of Dr. _____ Phone _____

Please Read:

* California Education Code 49408 states that school districts may require that emergency information be kept current.

** The parent or legal guardian of a public school pupil on a continuing medication regimen shall inform the school nurse or other designated certificated employee of the medication being taken.

*** California Education Code 49423 requires that if medications are to be taken at school, there must be a medication form on file at school, signed by both parent and physician.

EMERGENCY AUTHORIZATION

In the event of an emergency, when a parent/guardian is unavailable, I authorize school personnel to make such arrangements for my child to receive medical/hospital care, including necessary transportation, in accordance with their best judgment. I further authorize the physician named below to undertake such care of my child, as he/she considers necessary. In the event said physician is not available, I authorize such care and treatment to be performed by a licensed physician or surgeon. I understand that the parent or guardian is responsible for the cost of such emergency care.

Physician Name _____ Phone _____ Pager _____

Emergency Facility/Phone _____

Name of Insurance Coverage or Health Plan Provider: _____ Student's Medical Record Number _____

I certify that the information is true and correct. ☐ Please Initial

Parent/Guardian Signature _____ Date _____

Special instructions / comments: List any special health needs or medical problems, including allergic reactions.

Student's
Photograph