

# STUDENT EMERGENCY CONTACT CARD

Emergency Contact/ Medical Consent (Back)

Office Use Only

CSIS  
Date Enrolled

MEDICAL  
 CUSTODY  
 SPECIAL NEEDS

## STUDENT

\_\_\_\_\_

Last Name                      First                      Middle

Male \_\_\_\_\_  
 Female      Teacher/Advisor

\_\_\_\_\_

Home Address (Primary Residence)                      City                      State/Zip

\_\_\_\_\_

Home Phone                      Birthdate                      Birthplace

\_\_\_\_\_

Mailing Address, if different from above                      City                      State/Zip

Lives with:  Both Parents     Mother     Father     Legal Guardian  
Address change?  No     Yes    If Yes, please contact the School Office.

## PARENT/GUARDIAN

\_\_\_\_\_

Last Name                      First

\_\_\_\_\_ | \_\_\_\_\_

Email                      Employer

\_\_\_\_\_

Home Address, if different from above                      City                      State/Zip

\_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_

Home Phone                      Work Phone                      Cell Phone                      Pager

## PARENT/GUARDIAN

\_\_\_\_\_

Last Name                      First

\_\_\_\_\_ | \_\_\_\_\_

Email                      Employer

\_\_\_\_\_

Home Address, if different from above                      City                      State/Zip

\_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_

Home Phone                      Work Phone                      Cell Phone                      Pager

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 the names of relatives/neighbors/friends in close proximity to the school to which 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 school to contact the following individuals and release the student named above to them 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.*

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_ Relationship \_\_\_\_\_

Continued ⇨

# 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, 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): \_\_\_\_\_

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 \_\_\_\_\_

### SCHOOL PERMISSIONS

EPI-PEN

In the event of a life threatening allergic reaction, I authorize trained school personnel to give emergency treatment.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Photography

Under the federal Family Educational Rights and Privacy Act and California Education Code Sections 49076 and 49067(b), photographs are to be treated as pupil records. I hereby give the Alexander Valley School my permission to have my child's photograph taken as a school or class activity. I further give my permission to have my child's photograph taken in school and class and group settings on and off campus. I further give my permission to allow these photographs to be used in connection with school activities as in, but not limited to classroom activities, local newspapers, and the school yearbook.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_