Student Name: _____ **School:** _____
(Last) (First) (Middle)

School Year:_____ **Student Emergency Card** **Date:**_____

Student Information

Student Name: _____ **Sex:** ____ **Grade:** ___ **Birthdate:** _____
(Last) (First) (Middle)

Residence Address: _____
(Street) (City) (Zipcode)

Home/Primary Phone Number: _____ **Student's Birthplace:** _____

Parent/Guardian Information

Parent/Guardian 1	Parent/Guardian 2
Name _____	**Name** _____
Address _____	Address _____
City_____ Home Phone _____	City_____ Home Phone _____
Work Phone_____ Cell Phone _____	Work Phone_____ Cell Phone _____
Email Address _____	Email Address _____
Language Spoken at home: _____	**Student Lives With:** _____

Emergency Contacts

If the child listed above becomes ill, requires medical attention, or must be evacuated due to a emergency/disaster and I cannot be reached, the school authorities have my permission to contact and release my child to the care and custody of one of the following.

PLEASE NOTE: All persons picking up children MUST provide valid photo identification or your child will not be released.

1) Name_____ Relationship_____ Home Phone_____ Cell / Work Phone _____

2) Name_____ Relationship_____ Home Phone_____ Cell / Work Phone _____

3) Name_____ Relationship_____ Home Phone_____ Cell / Work Phone _____

Sibling Information

Name	School	Grade	Name	School	Grade
1.			2.		
3.			4.		

Medical Information

CHECK THE BOXES BELOW IF YOUR CHILD CURRENTLY HAS ANY OF THE FOLLOWING CONDITIONS:

☐ **Asthma (Inhaler Required)** ☐ **Diabetes** ☐ **Sickle Cell Anemia** ☐ **Severe Allergies (Epipen Required)**

☐ **Seizure Disorder (Date of last seizure:_____)** ☐ **Cystic Fibrosis** ☐ **Other:** _____

If you selected Seizure Disorder, what type of seizures did/does your child have: _____

Please list any medication(s) your child is required to take during school hours: _____

NOTE: Medical authorization forms must be completed by the physician annually for any medication/procedures required during school hours.

Disaster Preparedness Information

I will provide a 3-day supply of medication to the school (with current medical orders) for emergencies: ☒ **Yes** ☐ **No** ☐ **N/A**

My child has special care procedures or needs: ☐**Tracheostomy** ☐**GT Feedings** ☐**Catheterizations** ☐**Wheelchair**

Emergency Contact (Outside of California or outside the Bay area):

1) Name_____ Relationship_____ Home Phone_____ Cell / Work Phone _____

If my child needs to be taken to an emergency facility, he/she may be taken to the nearest one. I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I understand I will be financially responsible.

PARENT/GUARDIAN SIGNATURE:_____ **DATE** _____