

Student Name: \_\_\_\_\_  
(Last) (First) (Middle)

School: \_\_\_\_\_

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 \_\_\_\_\_