

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 _____