SCUSD Early Learning & Care Department
Complete All Information on Both Sides

EMERGENCY CARD
CONFIDENTIAL

Student Information
Please Print

School Year **School Site/Room #**

Student's Last Name (Legal) First Name Middle Date of Birth

Street Address Apt # City & Zip Code LANGUAGE SPOKEN AT HOME

Parent/Guardian 1 Name Cell Phone Other Phone

Address Relationship Driver's Lic # Email

Name & Address of Employment Work Phone

Parent/Guardian 2 Name Cell Phone Other Phone

Address Relationship Driver's Lic # Email

Name & Address of Employment Work Phone

Day Care Provider Phone #1 Phone #2

List names of other children attending this school

Parent/Guardian with whom the child lives Phone #

If the parents are divorced or separated, to who has physical custody of the child? (attach verification)

Additional Emergency Contacts

Name 1 **Name 2**

Phone # Relationship Phone # Relationship

Signature Signature

Name 3 **Name 4**

Phone # Relationship Phone # Relationship

Signature Signature

Name 5 **Name 6**

Phone # Relationship Phone # Relationship

Signature Signature

Special instructions / comments (include instructions for pickup of student)

Note: The adults listed above are authorized to pick up and care for the above-named student. The student may be released to others with written authorization.

Please Read:
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 (3) days 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 the above and understand my responsibility Parent/Guardian 1 Signature

I have read the above and understand my responsibility Parent/Guardian 2 Signature

CONTINUE ON REVERSE SIDE

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General Health Information

☐ **CHECK HERE IF THERE ARE NOT HEALTH PROBLEMS**

Does student wear glasses or contact lenses? ☐ Yes ☐ No

Does student wear hearing aids or is the student diagnosed with hearing loss? ☐ Yes ☐ No

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD

☐ ADD/ADHD ☐ Frequent ear infections ☐ Frequent headaches ☐ Frequent nose bleeds

☐ Asthma ☐ Ecema ☐ Heart Problems ☐ Seizures

☐ Diabetes ☐ Type I ☐ Type II ☐ Fainting Spells ☐ Seasonal Allergy ☐ Severe Allergy ☐ Epi-pen

Other

LIST ALL MEDICATION, WITH DOSE, TAKEN BY YOUR CHILD

AT HOME

AT SCHOOL

Does student have condition that limits participation in: ☐ classroom ☐ physical education

Explain

(NOTE: The physician must provide a note explaining the limitation and reason for the student's limited participation in physical education and *the note* ***must be updated every school year***)

SPECIAL INSTRUCTIONS/COMMENTS: List any special health needs or medical problems, including specific allergic reactions (food, bee sting, etc.), if student has an active emergency care plan, medical 504 Plan, Diabetic Medical Management Plan, etc.

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 require that if medications are to be taken at school, there must be a medication form on file at school, signed by both the parent and the 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 judgement. 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 Cell

Emergency Facility/Phone

Does this student have Health Insurance? ☐ Yes or ☐ No **Does this student have Dental Insurance? ☐ Yes or ☐ No**

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

If not, I give permission to SCUSD to share this information to help apply for health insurance for my child. ☐ Yes or ☐ No

By typing my full name, I confirm that the above information is true and correct.

Parent/Guardian Signature **Date**

CONTINUE ON REVERSE SIDE