

# Emergency Form

Student's Name: \_\_\_\_\_  Boy  Girl Grade: \_\_\_\_\_  
Last First Middle

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Home Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Mother or Guardian's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Father or Guardian's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

List other children at home and their dates of birth:

1. \_\_\_\_\_ 3. \_\_\_\_\_  
Month Day Year Month Day Year

2. \_\_\_\_\_ 4. \_\_\_\_\_  
Month Day Year Month Day Year

Check any health problems this student has:

Asthma  Diabetes  Epilepsy  Heart problems  Allergies (*specify*): \_\_\_\_\_

Other (*specify*): \_\_\_\_\_

List any medication this student takes: \_\_\_\_\_

In case of emergency, contact:

Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship to student: \_\_\_\_\_

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

## Emergency Medical Care Authorization

I am the parent or guardian of the child listed above. In case of an emergency, I give my permission to the school staff to consent to any emergency care for my child that an accredited, practicing doctor believes necessary. I give this authorization in advance so the school staff will be allowed to transport my child to a medical facility and give informed consent to emergency care if I cannot be reached. This authorization is allowed under the law (Calif. Civil Code, § 25.8). It stays in effect for the current school year or until I inform the school that I withdraw this authorization.

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

Student's Doctor (*name*): \_\_\_\_\_ Phone #: \_\_\_\_\_

Student's Dentist (*name*): \_\_\_\_\_ Phone #: \_\_\_\_\_

Health Insurance Plan: \_\_\_\_\_ Group #: \_\_\_\_\_

