

EMERGENCY INFORMATION
San Juan Unified School District

Grade _____ Room _____
Teacher/Counselor _____
Walk _____ or Bus # _____

NAME CHILD USES:

_____ Male Female
Child's full legal name: _____
Home Phone: _____ Address: _____
Cell Phone _____
Birthdate: _____

Parent(s) or Guardian child lives with: _____
Father: _____
Employer: _____
Mother: _____
Employer: _____
Check One: Natural Step Guardian/Foster Other Parent
Business Phone: _____
Check One: Natural Step Guardian/Foster Other Parent
Business Phone: _____

If my child is ill, has an emergency, or is suspended and I cannot be reached, please call and release my child to:
Name: _____ Phone: _____
Check one: Day Care Provider Neighbor Friend Relative Other: _____
Name: _____ Phone: _____
Check one: Day Care Provider Neighbor Friend Relative Other: _____

Physician's Name: _____ Medical Coverage by: _____ ID#: _____
Address: _____ Physician's Phone: _____ Hospital Preference: _____

PARENT MUST CHECK ONE
 1. In the event of an emergency, when a parent or guardian is unavailable, I authorize school personnel to make arrangements for my child to receive medical/hospital care, including necessary transportation, in accordance with their best judgment. I authorize the physician named above to undertake such care and treatment as is considered necessary. In the event said physician is unavailable, I authorize such care and treatment to be performed by a licensed physician or surgeon. I agree to pay all costs incurred as a result of the foregoing.
 2. I do not choose the above statement and desire the following action in the event of an emergency: _____

X _____ Date _____ X _____ Date _____
Parent/Guardian Signature

FORM #105971 REV 5/04

TURN CARD OVER AND COMPLETE HEALTH INFORMATION

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TURN CARD OVER AND COMPLETE HEALTH INFORMATION

PLEASE CHECK THE FOLLOWING ITEMS IF THEY PERTAIN TO YOUR CHILD

VISION:

- Wears glasses To be worn at all times
- Wears contacts To be worn at all times
- Requires preferential seating
- Date of last eye exam: _____
- Under care of Dr. _____ Phone: _____
- Comments: _____

HEARING:

- Has a hearing problem Has tubes in ears Uses hearing aid
- Requires preferential seating
- Under care of Dr. _____ Phone: _____
- Comments: _____

PLEASE READ AND SIGN

"I authorize the release of my child's medical information (1) by the school district and the provider of services to the billing agent and (2) by the school district to my insurance carrier as necessary to process a claim or to request payment of Medical Assistance Benefits. Shared information will be limited to health service documentation only."

Parent/Guardian Signature Date

Print Name Relationship

HEALTH CONCERNS:

1. Has the following condition(s):
 Asthma Seizures Migraines Diabetes
 Hyperactive (ADHD) Heart condition
 Allergies (describe): _____

 Allergic reaction to bee stings (describe): _____

 Other: _____
 Are any of the above life threatening? yes no (explain): _____

2. List medication prescribed: _____
 Current dosage: _____
 For (diagnosis): _____
 Prescribed by Dr. _____ Phone: _____
 Does the drug need to be taken during school hours? yes no
 "Medication in School" form on file (renew annually) yes no
3. Has a physical condition which limits participation in:
 Classroom activities Physical education
 (Please explain): _____

 Under care of Dr. _____ Phone: _____
4. School of former attendance: _____
 City: _____ State: _____

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