

# STUDENT EMERGENCY FORM

(Return to School Office)

Date \_\_\_\_\_ Room \_\_\_\_\_ Teacher \_\_\_\_\_

Student's Name: (Last) \_\_\_\_\_

(First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_

Other children/siblings at this school: (list name and grade)

1. \_\_\_\_\_

Birth Date: 

month			day					year

Sex:  Male  Female

2. \_\_\_\_\_

Parent/Guardian: Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Address: (If different from home above) \_\_\_\_\_

Phone: \_\_\_\_\_  
home work cell

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

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

Email address: \_\_\_\_\_

Child lives with:  Mother  Father  Caregiver/Guardian  Other \_\_\_\_\_

Language spoken at home: \_\_\_\_\_

**EMERGENCY AUTHORIZATION, CONTACT AND RELEASE INFORMATION:** In the event of an emergency, illness, accident, or disaster, please contact the parent(s) or guardian listed above. If unavailable, call others in the order listed. **My child is also authorized to be released to parent/guardian listed above and to the individuals listed below.**

Contact #2: Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Address: (If different from home above) \_\_\_\_\_ Phone: (home, work, cell) \_\_\_\_\_

Contact #3: Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Address: (If different from home above) \_\_\_\_\_ Phone: (home, work, cell) \_\_\_\_\_

**I authorize school authorities to take appropriate action for the safety/welfare of my child, including transport to the nearest emergency facility if necessary.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**My child SHOULD NEVER be released to the following:**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

## HEALTH INFORMATION

Physician/Clinic/Health Center where my child receives healthcare.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

### HEALTH CONDITIONS: *(current or history of)*

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Food/Medication Allergy <i>(please list)</i> _____ | My child takes the following medications: <i>(i.e.: inhalers, insulin, etc.)</i> _____ |
| <input type="checkbox"/> Diabetes          | _____   | _____  |
| <input type="checkbox"/> Bee Sting Allergy | _____   | _____  |
| <input type="checkbox"/> Seizures          | <input type="checkbox"/> Other <i>(please explain)</i> _____                | <input type="checkbox"/> This medication will be given at school.                      |
| <input type="checkbox"/> Wears glasses     | _____   |  |

### My child has health insurance:

Yes     No    If yes *(please list)* \_\_\_\_\_    Medi-Cal:     Yes     No

In the event of a life threatening allergic reaction, I authorize trained school personnel to give emergency treatment (adrenaline via epi-pen) to my child.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## PERMISSION TO TRANSPORT STUDENT

We, the undersigned (parents/guardians) of *(student's name)* \_\_\_\_\_, do hereby grant permission for the \_\_\_\_\_ School District, Sonoma County, CA to transport the above named student to and from school and to and from school-sponsored activities including, but not limited to study trips, and athletic and social events.

Signature \_\_\_\_\_ Date \_\_\_\_\_

OVER →