

**EMERGENCY INFORMATION**  
San Juan Unified School District

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

NAME CHILD USES:

\_\_\_\_\_  Male  Female

Child's full legal name: \_\_\_\_\_  
Last First Middle Birthdate:

Home Phone: \_\_\_\_\_ Address: \_\_\_\_\_  
No. Street Apt. City Zip

Cell Phone \_\_\_\_\_ Email Address (Optional) \_\_\_\_\_

Parent(s) or Guardian child lives with: \_\_\_\_\_  
If Parents are divorced or separated, to whom has physical custody been granted? (attach verification)

Father: \_\_\_\_\_ Check One:  Natural  Step  Guardian/Foster  Other Parent  
 Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Mother: \_\_\_\_\_ Check One:  Natural  Step  Guardian/Foster  Other Parent  
 Employer: \_\_\_\_\_ 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**

FORM #105971 REV 5/04

**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: \_\_\_\_\_

**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: \_\_\_\_\_

**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