

EMERGENCY & HEALTH INFORMATION

Today's date: _____

PERSONAL DATA

Student's Legal Name: _____

Likes to be called (nickname): _____ Date of Birth: _____

Telephone Number: _____ Other: _____

Mailing Address: _____
P.O. Box or Street City/State/Zip code

Physical Address: _____
Street/City/State/Zip code

Father/Stepfather/Guardian Name: _____

Employer: _____ Work Hours: _____

Business Phone: _____

Mother/Stepmother/Guardian Name: _____

Employer: _____ Work Hours: _____

Business Phone: _____

Please contact the following persons if parent/guardian(s) are not available.

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

CONTACT NUMBERS

Home: _____

Home: _____

Father's wk: _____

Mother's wk: _____

OTHER: _____

EMAIL: _____

How does your child get to/from school? Please circle all that apply.

Bus Routes:

AM/PM Pt. Arena/Manchester

AM/PM Ridge

AM/PM Coast

AM/PM Sea Ranch/Annapolis

Bus stop:

AM/PM Walks

AM/PM Personal vehicle

Student Assignment

Teacher: _____

Grade: _____ Rm.#: _____

HEALTH, PHYSICIAN / DENTIST INFORMATION & HEALTH INSURANCE COVERAGE

DOES YOUR CHILD HAVE ANY HEALTH CONCERNS AND/OR CONDITIONS? YES NO IF YES, PLEASE INDICATE BELOW.

_____ Allergies	_____ Asthma	_____ Attention Deficit Disorder	_____ Wears glasses	_____ Heart
_____ Bee stings	_____ Autism	_____ Deafness	_____ Diabetes	_____ Seizures
_____ Food	_____ Physical Handicap	_____ Vision	_____ Epilepsy	_____ Other: _____
_____ Drugs: _____				
_____ Other allergies				

LIST ANY MEDICATION YOUR CHILD USES FOR THE ABOVE CONDITION (S): _____

FAMILY PHYSICIAN: _____

Telephone #: _____

Address: _____

DENTIST: _____

Telephone #: _____

Address: _____

HEALTH INSURANCE AND ID#: _____

Emergency Authorization

If emergency treatment is required, and the parents or legal guardian cannot be reached, your signature in the space provided below empowers the school authorities to exercise their own judgment in calling the physician indicated above, or if not available, to transport the child to a hospital emergency room. Likewise, your signature below is not sufficient for the release of confidential information protected by Federal law.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

*California Education Code 49414: In the event that my child experiences a severe, life threatening anaphylactic (allergic) reaction during school hours or during school related activities, I/we

Give my/our consent

Do not give my/our consent

for trained designated school staff to administer the epinephrine auto-injector (Epi-pen) emergency treatment, under the indirect supervision of the school nurse.

Parent(s)/Guardian(s) Signature(s): _____ Date: _____