Santa Clara County Office of Education

STUDENT EMERGENCY INFORMATION

Please print or type and complete entire form. School:

STUDENT'S NAME: Date of Birth: ◯ Male ◯ Female

Last First

Address: Home Phone:

Street/Apt. # City Zip

Place of Birth: Primary Language Spoken at Home:

Country State City Does Student Speak/Understand English: ◯ Yes ◯ No

Student Lives With: ☐ Mother & Father ☐ Mother ☐ Father ☐ Foster Parent ☐ Group Home ☐ Other (specify):

Is there a Restraining Order against the Mother or Father? ◯ Yes ◯ No If yes, attach a copy and indicate against whom? ◯ Mother ◯ Father

Legal Guardian: ◯ Mother & Father ◯ Mother ◯ Father ◯ Foster Parent ◯ Group Home ◯ Other (specify):

Legal Guardian: Address:

Street/Apt. # City Zip

Mother's Information

Name:

Address:

Cell Phone: Work Phone:

E-Mail Address:

Work Days: Work Hours:

Father's Information

Name:

Address:

Cell Phone: Work Phone:

E-Mail Address:

Work Days: Work Hours:

EMERGENCY ALTERNATE/INFORMATION REQUIRED BY TRANSPORTATION: In the event of an emergency or your child cannot remain in school because of illness or injury, it may become necessary to transport your child home unexpectedly. List two adults (age 18 or older) in your neighborhood who have consented to take responsibility for your child should you not be home. (Please make sure these individuals bring photo identification with them to the school.)

1. Name: Phone#: 3. Name: Phone #:

2. Name: Phone#: 4. Name: Phone #:

In the event that no adult is available to accept your child, he/she will be taken to the Receiving & Intake Center at 725 E. Santa Clara, San Jose-Phone # (408) 792-1860

MEDICAL INFORMATION

(Use additional pages if necessary)

Medical Diagnosis/Disability:

Other Medical Concerns (check only those that apply):

☐ Breathing ☐ Heart ☐ Choking ☐ Shunt ☐ Bladder ☐ Hearing ☐ Vision ☐ Skin

Other (please explain):

Does your child have any know allergies? ◯ Yes ◯ No (If yes, please name specific allergy source from below)

Drugs: Food: Insect Bite: Other:

Describe reaction:

Does your child have seizures? ◯ Yes ◯ No If yes, type: Duration:

Describe seizure that would require hospitalization:

Does your child have special health/medical needs (i.e., tube feeding, catheterization, etc.)? ◯ Yes ◯ No If yes, please explain below.

Medications: List **all** medications that your doctor has ordered for your child (include dose and time). Please inform the school of any changes in the medication, the time, or the dosage.

1. 3.

2. 4.

Insurance Carrier: Name of Insured: Policy #:

Physician: Phone #: Address:

Dentist: Phone #: Address:

Medi-Cal #: Hospital Preference:

CONSENT FOR EMERGENCY TREATMENT: IF IT IS DEEMED NECESSARY BY THE SCHOOL AUTHORITIES, YOUR CHILD WILL BE TAKEN BY AMBULANCE AT PARENT'S EXPENSE TO THE NEAREST EMERGENCY FACILITY.

I AUTHORIZE AND DIRECT THE ATTENDNG PHYSICIAN/ DENTIST ON DUTY TO PERFORM EMERGENCY TREATMENT ON MY CHILD.

PARENT'S SIGNATURE: **DATE:**

PLEASE NOTIFY THE SCHOOL IMMEDIATELY IF ANY OF THE ABOVE INFORMATION CHANGES.

Original – Student's Cum. Folder Copies to Parent, Nurse, and Transportation

Revised 7/13/16