Santa Clara County Office of Education

STUDENT EMERGENCY INFORMATION

Please print or type and complete entire form. School: _____

STUDENT'S NAME: _____ Date of Birth: _____
Last First

Primary Student Address: _____ Home Phone: ( ) _____
Street City Zip

Place of Birth: _____ Primary Language Spoken at Home: _____
Country State City Does Student Speak/Understand English: ☐ Yes ☐ No

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: _____

Father's Information

Name: _____

Address: _____

Cell Phone: _____ Work Phone: _____

E-Mail Address: _____

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#: _____ 2. 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.

Revised 7/29/22