CAMPTONVILLE UNION ELEMENTARY SCHOOL DISTRICT

• STUDENT EMERGENCY INFORMATION • 2021-2022

Student Name _____ Grade _____ Sex _____ Birth Date ____/____/____

Mailing Address: _____ Phone _____
City: _____ ___ State: _____ Zip:_____

Residence Address: _____
City: _____ State: _____ Zip:_____

Residency Verification:
I declare under penalty of perjury, under the laws of the State of California, that the above street address is the correct residence for my student.

_____ _____ _____
Parent/Guardian Name Parent/Guardian Signature Date

With whom does student live?

[ ] Mother or [ ] Step Mother
Name: _____
Employer: _____
Phone: Work _____/Cell_____

[ ] Father or [ ] Step Father
Name: _____
Employer: _____
Phone: Work _____/Cell_____

[ ] Guardian
Name: _____
Employer: _____
Phone: Work _____/Cell_____

Non-Resident Guardian: Other legal guardian's address if student not living with him/her.
Name: _____ Phone: _____
Mailing Address: _____ City/Zip:_____

If you cannot be reached in case of illness/injury, please give the names of persons who will assume temporary responsibility for your student: (*Someone in the area. Student only released to persons indicated below*.)

Name	Relationship to Student	Home Phone	Work Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Doctor's Name: _____Phone:_____
Dentist's Name: _____Phone: _____
Health Plan/Insurance: _____
Group/Policy #: _____

(Please complete other side.)

Please check the following items that pertain to your student:

STUDENT HAS NO KNOWN HEALTH PROBLEMS [ ]

EYES: [ ] Wears glasses/contacts [ ] Need to be worn at all times

EARS: [ ] Has hearing problem [ ] Tubes in ears [ ] Hearing aid [ ] Requires preferential seating

GENERAL HEALTH: Has the following condition(s):
[ ] Seizures [ ] Fainting Spells [ ] Diabetes [ ] Heart Condition [ ] ADHD/ADD [ ] Migraines
[ ] Asthma [ ] Other health problems. *Describe*: _____
_____
[ ] Allergic Reaction to Bee Stings *Describe:* _____
[ ] Food Allergies *Describe*: _____
[ ] Medication Allergies *Describe*: _____

LIST MEDICATION PRESCRIBED:
Name and dosage: _____
For (diagnosis): _____
Does the drug need to be taken during school hours? [ ] *Yes [ ] No
Prescribed by Dr._____ Phone: _____

Note:** Student **MUST** have a medication authorization form, signed by doctor and parent/guardian, on file in the school office in order to take any prescription at school or on field trips. (**Forms must be renewed annually**.) Over-the-counter medication must have authorization form on file signed by parent/guardian. ***All medication must be in original container.

In the event of an emergency, if a parent or guardian cannot be reached, I hereby give my permission for the school authorities to render first aid and, when deemed necessary, secure medical help or ambulance service at my expense.

As a legal custodian of _____, a minor, I hereby authorize the superintendent or his/her designees, into whose care the aforementioned minor pupil has been entrusted, to consent to any x-ray, examination, anesthetic, medical diagnosis, treatment, and/or hospital care to be rendered to said minor upon the advice of any licensed physician and/or dentist.

I understand that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary.

This authorization shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand that the Camptonville Union Elementary School District, its employees, and its Board assume no liability of any nature in relation to the transportation or treatment of said minor. I further understand that all costs of paramedic transportation, hospitalization, and examination, x-ray, or treatment provided in relation to this authorization shall be my responsibility.

I understand that the Camptonville Union Elementary School District does provide "school-time accident" insurance to help with the cost of medical treatment not covered by other insurance I may have. This "school-time accident" insurance is designed to cover some, but not all, of the possible costs.

I understand the information given on this card will be used as a permanent guide for emergency care for my student and it is my responsibility to notify the school of any change.

[ ] I have read the above statements and agree.

[ ] I do not choose the above statement and desire the following action in the event of an emergency:
_____
_____

Parent/Guardian Signature: _____ **Date:** _____

Email address: