HEALTH/EMERGENCY CARD

FOR OFFICE USE ONLY
DATE ENTERED: ______
SASI I.D. # ______

STUDENT NAME: ______ (Last / First / Middle) GRADE: ______

LEGAL NAME: (If Different) ______ (Last / First / Middle) BIRTH DATE: ______ HOME PHONE: ______

ADDRESS: ______ Zip Code SOCIAL SECURITY # ______ - ______ - ______

RACE/ NATIONALITY: ______ SEX: ☐ M ☐ F ☐ TWIN Student Lives With: (check one) ☐ Father ☐ Mother ☐ Guardian

FATHER: ______ Home Phone: ______
Address: ______ Zip Code: ______
Where Employed: ______
Work Phone: ______ Cell Phone: ______

MOTHER: ______ Home Phone: ______
Address: ______ Zip Code: ______
Where Employed: ______
Work Phone: ______ Cell Phone: ______

STEP MOTHER: ______ Home Phone: ______
Address: ______ Zip Code: ______
Where Employed: ______ Work Phone: ______

STEP FATHER: ______ Home Phone: ______
Address: ______ Zip Code: ______
Where Employed: ______ Work Phone: ______

GUARDIAN(S): ______ Home Phone: ______
Address: ______ Zip Code: ______
Check One: ☐ Foster Parent ☐ Group Home ☐ Relative Cell Phone: ______
Where Employed: ______ Work Phone: ______

BROTHERS AND SISTERS IN SCHOOL UNDER AGE 18 LIVING AT HOME:

Name: ______ B.D. ______ Name: ______ B.D. ______

Name: ______ B.D. ______ Name: ______ B.D. ______

Name: ______ B.D. ______ Name: ______ B.D. ______

Name: ______ B.D. ______ Name: ______ B.D. ______

PLEASE FILL OUT REVERSE SIDE

EMERGENCY AND HEALTH INFORMATION

In case of emergency, illness or accident to: ______ (Student's Name) and the school is unable to reach parents/guardians, the school is authorized to proceed as indicated below:

CALL FIRST: PARENTS/GUARDIAN (See Reverse Side)

CALL SECOND: ______ Name / Relationship / Daytime or Work Address / Daytime or Work Phone

CALL THIRD: ______ Name / Relationship / Daytime or Work Address / Daytime or Work Phone

CALL FOURTH: ______ Name / Relationship / Daytime or Work Address / Daytime or Work Phone

CALL PHYSICIAN: ______ Name / Address / Telephone Number

If it is not possible to contact any of the above listed persons, I hereby authorize transportation to the nearest medical facility for such emergency medical treatment as deemed necessary for the safety and protection of my child, but not at the expense of the school.

THIS INFORMATION MUST BE COMPLETED YEARLY SO THAT THE SCHOOL CAN ACT ON YOUR BEHALF IN THE EVENT IF A MEDICAL EMERGENCY

PLEASE CHECK STUDENT'S PAST OR PRESENT ILLNESS:
☐ Heart Condition ☐ Diabetes
☐ Asthma ☐ Epilepsy or Convulsions

☐ Serious Allergies (Describe) ______
______ (Bee sting, Penicillin reaction, etc.)

Any other serious illness, operation, or physical handicap?

Describe Problem: ______

Any limitations in school activities due to illness? ☐ Yes ☐ No
______

Describe: ______

Does your child require continuing medication for health problems? ☐ Yes ☐ No Medication Prescribed: ______

If medication is necessary during the school day, a written statement from a physician and the parent is required.

I understand that the school district does not provide medical insurance for student injuries but does make voluntary student insurance available. I have received the information on this program.

I will enroll my child in the STUDENT INSURANCE PROGRAM: ☐ Yes ☐ No

Has your child received any additional immunizations during the past year? ☐ Yes ☐ No

What kind? ______ Date: ______

☐ **Student Has No Health Insurance or Medi-Cal**

☐ **Health Insurance / Medi-Cal** ______ Policy # ______ ID #: ______

I authorize the release of medical information by the school district to its billing agency and to my insurance company to process a claim or request reimbursement for medical services rendered to my child. Any shared information will be limited to service documentation only.

Signature of Parent/Guardian ______ Date: ______