

COLTON JOINT UNIFIED SCHOOL DISTRICT

STUDENT EMERGENCY INFORMATION FORM



Please fill in the information requested completely and accurately

(OFFICE USE ONLY) DATE: _____ TEACHER: _____ GRADE _____ STUDENT ID# _____

Student's Information

Last Name		First Name		Middle Name
Grade:	Birthdate:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Non-binary	Student Contact #: <input type="checkbox"/> Student Cell <input type="checkbox"/> Parent Cell <input type="checkbox"/> Home Phone <input type="checkbox"/> Student may receive text message notifications	
STUDENT'S HOME ADDRESS:				
ADDRESS		CITY	ZIP CODE	
STUDENT'S MAILING ADDRESS (IF DIFFERENT FROM ABOVE)				

Parent/Legal Guardian/Caregiver enrolling student with whom the student lives with on a day to day basis:

PARENT/LEGAL GUARDIAN/CAREGIVER LAST NAME		FIRST NAME		RELATIONSHIP TO STUDENT:
Home Address:		Apt #	City:	Live with student <input type="checkbox"/> State: _____ Zip: _____
EMPLOYER:		PRIMARY PH# _____		CELL PH# _____
Address: _____ WORK PH#: _____		EMAIL ADDRESS: _____		Receive text messages <input type="checkbox"/>
PARENT/LEGAL GUARDIAN/CAREGIVER LAST NAME		FIRST NAME		RELATIONSHIP TO STUDENT:
HOME ADDRESS:		Apt #	City:	Live with student <input type="checkbox"/> State: _____ Zip: _____
EMPLOYER:		PRIMARY PH# _____		CELL PH# _____
Address: _____ WORK PH# _____		EMAIL ADDRESS: _____		Receive text messages <input type="checkbox"/>

EMERGENCY CONTACTS

In case the school is **unable to reach** parent/legal guardian/caregiver the following responsible adults may be contacted in case of an emergency or disaster. Person must be 18 years or older with a valid contact number.

Emergency contact #1

First/Last Name: _____ Contact #: _____

Relationship: _____

Emergency contact #2

First/Last Name: _____ Contact #: _____

Relationship: _____

Emergency contact #3

First/Last Name: _____ Contact #: _____

Relationship: _____

Where is your child/family currently living: (check one box only)

This information will be used to determine if your child qualifies for additional assistance under the McKinney Vento Act.

- In a single family residence (only 1 family living in this residence)
- In a hotel/motel
- With more than one family in a residence **not** due to economic hardship
- In a shelter or transitional housing
- With more than one family in a residence due to economic hardship
- Temporarily unsheltered (car, etc.)
- In a foster care placement/group home
- Living with other than parent/legal guardian temporarily—Caregiver Aff.

UNITED STATES ARMED FORCES

Is either parent/guardian on **Active Duty** in the Armed Forces or National Reserve:

yes no If yes, date started: _____

Is other parent/guardian on Full-time National Guard Duty:

yes no If yes, date started: _____

Names of siblings in District and/or in the Home:

Name: _____ School: _____ dob: _____

Name: _____ School: _____ dob: _____

Name: _____ School: _____ dob: _____

Name: _____ School: _____ dob: _____

Medical History:

My child is allergic to the following medications/food/insect bites:

None

My child takes the following medications at school:

My child takes the following medications at home:

Health Plan/Insurance Co. _____

Group Policy #: _____

My child has the following health problems: _____

My child has no medical issues:

None

Parent Initials: _____

Family Doctor: _____

Daytime Ph#: _____

Address: _____

Parent's Rights

I have read the information on this form and understand its content. My signature verifies that I have been informed of my rights as a parent/legal guardian/caregiver of a public school student. My signature DOES NOT indicate consent to participate in a particular program. I will send written notice to the school of any specific objections I have regarding my student's participation in a particular program or service. I understand that the health information may be shared verbally or in writing with school district personnel.

Signature of Parent/Legal Guardian/Caregiver: _____

Date: _____

- I object to the release of student information of my student
- I **do not** object to the release of student information of my student

Parent initials: _____ Date: _____

As legal custodian of _____, a minor, I hereby authorize the principal or his/her designee, into whose care the aforementioned minor pupil has been entrusted, to consent to any X-ray, examination, anesthetic, medical or surgical 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 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 unless revoked in writing and delivered to said agent(s). I understand that the Colton Joint Unified 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 any examination, X-ray, or treatment provided in relation to this authorization shall be my responsibility.

Signature of Parent/LegalGuardian/Caregiver: _____

Date: _____