COLTON JOINT UNIFIED SCHOOL DISTRICT

Student Emergency Card

Student's Name

Last Name First Name Middle Name

Student Contact ( ) Birth Date

☐Student Cell ☐Parent Cell ☐ Home Phone

Address

City Zip

Mother's Name

(Circle One: Mother, Step Mother, Guardian)

Address

City Zip

Primary Phone( ) Cell( )

☐ **Unlisted** **Receive Text messages** ☐ Yes ☐ No

Place of Business

Work Phone ( ) Ext.

E-mail Address

Father's Name

(Circle One: Father, Step Father, Guardian)

Address

City Zip

Primary Phone ( ) Cell( )

☐ **Unlisted** **Receive Text messages** ☐ Yes ☐ No

Place of Business

Work Phone ( ) Ext.

E-mail Address

Names of Brothers and Sisters in District and/or in the Home:

School DOB ___/___/____

School DOB ___/___/____

School DOB ___/___/____

United States Armed Forces:

Is either parent/guardian on Active Duty in the Armed Forces or National Reserve? ☐Yes ☐No

If so, which branch: ☐ Air Force ☐ Army ☐ Coast Guard ☐ Marine Corps ☐ Navy

If Yes, date started?

Is other parent/guardian on Full-Time National Guard Duty? ☐ Yes ☐ No

If Yes, date started? ____/____/_____

Grade **Student ID** (Office use only)

School **Date**

Emergency Contacts: *Responsible persons, other than yourself, who the school can contact to pick up or be called in case of an emergency or disaster (**18 years or older**):*

1. First/Last Name

Relationship Phone( )

(Circle One: Home Work Cell)

2. First/Last Name

Relationship Phone( )

(Circle One: Home Work Cell)

3. First/Last Name

Relationship Phone( )

(Circle One: Home Work Cell)

4. First/Last Name

Relationship Phone( )

(Circle One: Home Work Cell)

Family Doctor

Address

City Daytime Phone ( )

Health Plan/Insurance Co.

Group/Policy #

Medical History:

My Child is allergic to the following medications/food/insect bites: None ☐

My Child takes the following medications at home:

My Child takes the following medications at school:

My Child has the following health problems:

My Child has no medical issues: ☐ Parent Initials:

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 ☐ With more than one family in a house or apartment due to economic hardship or loss of housing ☐ Living with Others (Caregiver Affidavit)

☐ In a shelter or transitional housing program ☐ In a motel/hotel ☐ Temporarily unsheltered (car, camp site, etc) ☐ In a foster care placement or group home

Parents 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/guardian 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 or Guardian ***Date***

☐ **I OBJECT** to the release of student information. ☐ **I DO NOT OBJECT** to the release of student information.

I understand that the Colton Joint Unified School District does not provide accident medical insurance for students for school related injuries but does offer student accident insurance for voluntary purchase. I have received the information and application for this program.

Please Check One: ☐ I will enroll my child in the program ☐ I will not enroll my child in the program.

Signature of Parent or Guardian ***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 for the full school year 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 or Guardian ***Date***

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