

STUDENT EMERGENCY CONTACT CARD

Medical Information and Consent

STUDENT

Last _____ First _____ Middle _____

MEDICAL/HEALTH INFORMATION

Medication: Does your child require medication at school or at home? No Yes

➔ If your child requires medication at school, all medication sent to school must be in the original prescription container with a current date and the child's name. An "Authorization for Administration of Medication" form must be on file. For disasters, please provide a separate three-day supply for the school office, in the same format, with the along with the green "72-Hour Disaster Medication" form. Both forms are available from the school office. Include prescribing Physician's name, per Ed Code 49480.

Medication	Prescribing Physician	Dosage	Hour(s) given

Physician/Health Care Provider _____ Phone No. _____

Health Insurance Information: *Please check appropriate box.*

- Family Health Insurance Healthy Families California Kids
- Medi-Cal # _____ No Health Insurance

Health Plan/Group Name _____ Policy No. _____

Dentist _____ Phone No. _____

Vision and/or Hearing Problems:

- Wears glasses/contacts: ➔ for board work for reading all the time
- Date of last eye exam _____ Wears hearing aid(s)

Medical Conditions: Please check the appropriate boxes if your child has any of the following:

- Severe allergies requiring: ➔ Epi-pen Benadryl Latex
- Food/Environmental Stinging Insects/Bees Medications Other

Please explain: _____

- Current asthma If checked, ➔ uses inhaler on daily medication
- Current seizures If checked, on medication? ➔ Yes No
- Diabetes If checked, insulin dependent? ➔ Yes No
- Behavior problems: _____
- Movement limitations: _____
- Other (please explain): _____

Recent illness, hospitalization or surgery. If checked, please provide date(s) and description(s): _____

Medical condition which might require care or accommodation at school (please describe): _____

EMERGENCY TREATMENT AUTHORIZATION

I/we, the undersigned parent(s) or legal guardian of _____, a minor, do hereby give authorization and consent to the school to obtain emergency medical care and necessary transportation, including x-ray examination, anesthesia, medical or surgical diagnosis and emergency hospital which is deemed advisable by and is to be rendered under the general or specific supervision of medical and emergency room staff licensed under the provisions of the medicine practice act and the State of California Department of Public Health.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the student, but that any of the above treatment will not be withheld if the undersigned or authorized adults cannot be reached.

I/we prefer for emergency medical treatment of _____ is the hospital my/our child.

I/we understand that the school district does not provide accident/medical insurance for students, and I/we further understand that all costs related to medical treatment may be my/our responsibility and not that of the school district.

Parent/Guardian Signature _____ Date _____

VOLUNTEER ASSISTANCE

If you live close to school and feel that, if called, you can offer volunteer assistance during an emergency, please provide your name, phone number and expertise.

I would like to help in an emergency.

Name _____ Phone _____

Qualifications _____