

SAN DIEGUITO UNION HIGH SCHOOL DISTRICT EMERGENCY FORM

The following information is necessary for the Student Health Record.
Please complete this form, **sign** and **return** to your school annually. This is not a "change of residency" form.
***If you have changed your residence, please complete and submit a "Verification of Residency Form"**
available at your student's school registrar's office.

STUDENT: Last _____ **First** _____ **Middle** _____ **DOB: Month/Day/ Year** _____ Male Female
NAME

Address Where the **Student Resides Currently** Apartment # _____ City _____ Zip Code _____ School _____ Grade _____

Student Cell Phone _____ Student Email _____

Please check which Parent/Guardian should be contacted first:

Father _____ Mother _____

Father's Name _____ (Please indicate: Father/Guardian) Mother's Name _____ (Please indicate: Mother/Guardian)

Home Phone # _____ Cell # _____ Home Phone # _____ Cell # _____

Place of Employment /Department _____ Work Phone # _____ Place of Employment /Department _____ Work Phone # _____

Father's E-mail Address _____ Mother's E-mail Address _____

Father's Current Address **Is This a New Address?** No *Yes Mother's Current Address **Is This a New Address?** No *Yes

Mailing Address (If different than above) _____ Mailing Address (If different than above) _____

Father's Years of Education: _____ Language _____ # of years Mother's Years of Education: _____ Language _____ # of years

Father needs interpreter for phone calls and meetings: NO YES Mother needs interpreter for phone calls and meetings: NO YES

ADDITIONAL CONTACTS: CONTACTS MUST BE LOCAL - List contacts for **two adults** other than parent/guardian.
If parent/guardian cannot be reached, we authorize the school staff to release the student to:

1) Local Contact: _____
Adult's Full Name Relationship to Student Home / Work Number Cell Number

2) Local Contact: _____
Adult's Full Name Relationship to Student Home / Work Number Cell Number

MEDICAL INFORMATION: EC §49423

Name of Student's Physician/Clinic: _____
Name Address Phone # Physician/Clinic

Does the student take continuing medication: NO YES
Will it be necessary to take medication at school? NO YES

If student requires administration of medication during school hours, parent must complete and deliver to the school's Health Office the "**Authorization for Administration of Medication**" form signed by parent and physician. The form is available at: www.sduhsd.net

EMERGENCY: In an emergency, I give my consent: For family physician, EMT and/or hospital to provide emergency treatment to my son/daughter: NO YES

Signature of Father/Guardian _____ Date _____ Signature of Mother/Guardian _____ Date _____