SAN DIEGUITO UNION HIGH SCHOOL DISTRICT

EMERGENCY FORM 2016/17

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 Name _____ **First Name** _____ Initial ____ ☐ Male ☐ Female Date of Birth Month/Day/ Year _____ ID# Student Identification _____

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/Tutor) _____

Home Phone # _____ Cell # _____

Place of Employment /Department _____ Work Phone # _____

Father's E-mail Address _____

Father's Current Address **Is This New Address?** No ☐ ***Yes** ☐ _____

Mailing Address (If different than above) _____

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

Father needs interpreter for phone calls and meetings: **NO** ☐ **YES** ☐

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

Home Phone # _____ Cell # _____

Place of Employment /Department _____ Work Phone # _____

Mother's E-mail Address _____

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

Mailing Address (If different than above) _____

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

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

I give my consent for school personnel to communicate with my son/daughter's physician NO ☐ **YES** ☑

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: http://www.sduhsd.net/downloads/

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** ☐

Student has medical insurance? NO ☐ YES ☐ Medical insurance in: Father's name ☐ Mother's name ☐

Medical Insurance Carrier _____ Policy Number / Group _____ Insurance Contact Number/s _____

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

Revision 11-15