

# 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](http://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 \_\_\_\_\_