



PLEASE CHECK BOX IF NEW INFORMATION

STUDENT EMERGENCY FORM

Teacher: _____

School Year 2020-2021

DEMOGRAPHIC INFORMATION

Student Legal Last Name	Legal First Name	Legal Middle Name	Gender	Grade	DOB
			<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Declared		
Nickname:	Preferred Gender Pronoun:	Previous School Attended:			

TRANSPORTATION AND RELATED INFORMATION

Check the boxes below if your child rides the bus.
 To School From School Bus # _____

Daycare Provider: _____
 Phone #1: _____ Phone #2: _____

PARENT EDUCATION: Check the box that best describes the highest education level of either parent/guardian.

Not a High School Graduate High School Graduate Some College (includes AA degrees)
 College Graduate Graduate Degree or Higher

PRIMARY HOUSEHOLD: *This is the address where the student primarily lives.*

Primary Household Address: _____

Parent/Guardian	Full Legal Name:	DOB:	Email:
Home Phone:	Cell Phone:	Work Phone:	
Other adult in household	Legal Name:	DOB:	Email:
	Cell Phone:	Work Phone:	

SECONDARY HOUSEHOLD: *Complete the address section **ONLY** if the parents **do not** live in the same household.

Secondary Household Address: _____

Parent/Guardian	Full Legal Name:	DOB:	Email:
Home Phone:	Cell Phone:	Work Phone:	
Other adult in household	Legal Name:	DOB:	Email:
	Cell Phone:	Work Phone:	

AUTOMATED MESSENGER CONTACT INFORMATION: Check to *receive automated messages.*

	Attendance	Behavior	General	Teacher	Priority
Primary Guardian's Email Address	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary Guardian's Home Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary Guardian's Cell Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary Guardian's Work Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secondary Guardian's Email Address	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secondary Guardian's Home Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secondary Guardian's Cell Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secondary Guardian's Work Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NON-HOUSEHOLD EMERGENCY CONTACTS: *Authorized to pick up and care for the student with written or verbal permission.*

Name:	DOB:	Relationship to student:	Primary Phone Number:
Name:	DOB:	Relationship to student:	Primary Phone Number:
Name:	DOB:	Relationship to student:	Primary Phone Number:

PLEASE READ: California Education Code 49408 states that school districts can require that emergency information be kept current. Parent/guardian is responsible for notifying the school, in writing, of telephone or address changes with three (3) days of occurrence. If the school is unable to reach anyone on this form in an emergency or if a student is left unattended during non-school hours, the school will contact law enforcement or Child Protective Services.

Parent/Guardian Initials: _____

HEALTH AND EMERGENCY INFORMATION

- Check here if student has **NO KNOWN HEALTH PROBLEMS**.
- Check here if student has **KNOWN HEALTH PROBLEMS** and check all that apply below.
- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | ___ Type I ___ Type II |
| <input type="checkbox"/> SEVERE Allergy to: _____ | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Epi-Pen | | |

- | | |
|--|---|
| <input type="checkbox"/> Check here if student wears glasses/contact lenses. | <input type="checkbox"/> Check here if student has hearing loss or uses hearing aids. |
|--|---|

Does student have a condition that limits participation in: Classroom Physical Education
Explain: _____

List all medications (including dosage) taken by your child and indicate whether medication is needed at home, school, or both. *Note: California Education Code 49423 requires that if medications are to be taken at school, there must be a medication form on file at school, signed by both parents and physician. Parent or guardian shall inform the school nurse or designated certificated employee of the medication being taken.*

AT HOME _____

AT SCHOOL _____

WHAT SPECIAL SERVICES DOES YOUR CHILD RECEIVE? (Check all boxes that apply)

- | | | | |
|--|------------------------------|--|--|
| <input type="checkbox"/> Resource (RSP) | <input type="checkbox"/> 504 | <input type="checkbox"/> Speech & Language | <input type="checkbox"/> Gifted (GATE) |
| <input type="checkbox"/> Special Day Class (SDC) | <input type="checkbox"/> IEP | <input type="checkbox"/> English Learner Support | <input type="checkbox"/> NONE |

Special Instructions/Comments (Medical 504 Plan, special health needs, emergency care plan, etc.):

EMERGENCY AUTHORIZATION

In the event of an emergency, when a parent/guardian is unavailable, I authorize school personnel to make such arrangements for my child to receive medical/hospital care, including necessary transportation, in accordance with their best judgment. I further authorize the physician named below to undertake such care of my child, as he/she considers necessary. In the event said physician is not available, I authorize such care and treatment to be performed by a licensed physician or surgeon. I understand that the parent or guardian is responsible for the cost of such emergency care.

Physician Name _____ Phone _____ Pager _____

Emergency Facility and Phone Number _____

Does this student have health insurance? Yes No Does this student have dental insurance? Yes No

Name of Insurance or Health Plan Provider: _____ Student's Medical Record Number: _____

If not, I give permission to SCUSD to share this information to help apply for health insurance for my child. Yes No

The information provided is accurate to the best of my knowledge, and I understand my responsibility.

X _____
Legal Name/Signature of Parent/Guardian Registering Student Relationship to Student Date