Year: 2019-20 **Grade:** _____

Teacher: _____ **ID#:** _____

SAN MARCOS UNIFIED SCHOOL DISTRICT
STUDENT EMERGENCY CARD

X _____ _____ _____ _____

Last Name **First Name** **Middle Name** **Birthdate**

X _____ _____ _____

Home Address **Home Phone** **Parent E-Mail Address**

IN CASE OF AN EMERGENCY, IT IS IMPORTANT FOR THE SAFETY OF YOUR CHILD THAT WE HAVE INFORMATION REQUESTED BELOW.

1._____ _____ _____ _____

Name (Parent) Employer Cell Phone Work Phone

2._____ _____ _____ _____

Name (Parent) Employer Cell Phone Work Phone

IT IS VERY IMPORTANT, IN CASE PARENTS CANNOT BE REACHED, THAT TWO (2) ADDITIONAL NAMES AND TELEPHONE NUMBERS BE LISTED BELOW:

3._____ _____ _____

Alternate Local Contact Name Relationship Phone

4._____ _____ _____

Alternate Local Contact Name Relationship Phone

IF NONE OF THE ABOVE IS AVAILABLE, YOUR CHILD WILL BE TRANSPORTED BY AMBULANCE TO THE HOSPITAL.

Siblings in school:

Name	School	Grade	Name	School	Grade

HEALTH CONDITION(S)- Check all that apply

IF NO HEALTH PROBLEMS check here ☐

☐ ADHD

☐ Asthma, needs Inhaler at school: ☐Yes ☐No

☐ Diabetes, needs Insulin at school: ☐Yes ☐No

☐ Heart Problem, explain:_____

☐ Seizure Disorder, explain:_____

☐ Known Hearing Loss , wears hearing aide(s): ☐ R ☐ L

☐ Vision Problem ☐ Wears Glasses ☐ Wears Contact Lenses

☐ Other Health Problem, explain:_____

☐History of concussion, date(s): _____

ALLERGIES- Check all that apply

IF NO KNOWN ALLERGIES check here ☐

☐ Bee Sting Allergy

☐ Food Allergy, list foods:_____

_____

☐ Medication Allergy, explain:_____

☐ Other Allergy, explain:_____

☐ **Check here if your child has had an Anaphylactic Reaction**

Does your child require medication to treat allergies: ☐Yes ☐No

IF MEDICATIONS ARE REQUIRED TO TREAT AN ALLERGIC REACTION, PLEASE CONTACT THE SCHOOL HEALTH OFFICE OR CHECK THE SCHOOL WEB SITE TO OBTAIN THE REQUIRED FORMS.

MEDICATION(S)- List medications below. IF NONE, Check Here ☐

Medication name/dose/time taken:_____

Are any of the listed medications taken at school? ☐Yes ☐No

IF MEDICATIONS ARE REQUIRED AT SCHOOL, A SIGNED PARENT PERMISSION FORM AND PHYSICIANS ORDER IS REQUIRED. PLEASE CONTACT THE SCHOOL HEALTH OFFICE OR CHECK THE SCHOOL WEB SITE TO OBTAIN THE REQUIRED FORMS.

MEDICAL CARE PROVIDER PHONE NUMBERS-

Physician Name/Phone:_____ Dentist Name/Phone:_____

Does your child have Health Insurance? ☐Yes ☐No Name of Insurance Provider:_____

THE HEALTH INFORMATION PROVIDED IN THIS FORM MAY BE SHARED WITH APPROPRIATE SCHOOL PERSONNEL ON A NEED-TO-KNOW BASIS IN ORDER TO PROVIDE FOR YOUR CHILD'S SAFETY AND WELL-BEING.
PLEASE CONTACT THE SCHOOL NURSE WITH ANY CONCERNS OR QUESTIONS IN THIS REGARD.

Signature(s) of Parent(s) or Guardian(s):_____ Date:_____

I hereby certify the above information to be true and correct to the best of my knowledge.