

COURT ORDER
 MEDICAL ALERT

Required Emergency Card Information

Student ID# _____
Family Number _____
Dwelling # _____ Rm # _____

Student's Legal Name: _____ Birthdate: _____ Sex: male female

Student's Social Security Number: _____ - _____ - _____ Teacher _____ Grade: EC Pre-K

Address _____ Home Phone: _____
Street City Zip

Language Spoken by child: _____ Language spoken by parent: _____

Student lives with both parents? Yes or No If no, which parent does student live with: _____

<u>Name:</u>	<u>Last</u>	<u>First</u>	<u>Work Phone</u>	<u>Hours</u>	<u>Cell Phone</u>	<u>Other</u>
Father			()		()	
Mother						
Other						

List the persons you authorize to care for your child in an emergency situation if we are unable to reach you. (Must be 18 years or older)

<u>Name</u>	<u>Relationship</u>	<u>Address</u>	<u>Day Phone</u>

Doctor: _____ Phone #: _____ Dentist: _____ Phone #: _____

Student's Health Insurance: _____ I.D. #: _____

Siblings In SCUSD:
Name: _____ School: _____ Grade: _____
Name: _____ School: _____ Grade: _____
Name: _____ School: _____ Grade: _____

The school seeks advice and cooperation of parents and physicians in maintaining the health of pupils. In order that we may know more about your student's health, please complete the information below.
Please list your student's health problems, if any. (Diabetes, allergies, asthma, heart problems, etc.)

Vision Difficulties: Yes or No **Eye Glasses:** Yes or No **Hearing Difficulties:** Yes or No

Is he/she able to participate in the regular education program? Yes or No If not, please explain:

Please complete the flowing section if your student is taking medication on a continuing basis:

Name of medication: _____ Current Dosage: _____

Reason for medication: _____

Physician supervising treatment: _____ Phone #: _____

Re: Medication at School - Should it be necessary for your child to take medication at school, you must provide the school with the physician's written instructions and your written permission. Forms for this purpose are available from the school. Medication at school must be kept in the original pharmacy container. Students are not to have medication in their possession (including aspirin or cough drops).

<p>CONSENT FOR EMERGENCY TREATMENT: (IF IT IS DEEMED NECESSARY BY THE SCHOOL AUTHORITIES, YOUR CHILD WILL BE TAKEN BY AMBULANCE AT THE PARENT'S EXPENSE TO THE NEAREST EMERGENCY FACILITY.)</p> <p>I AUTHORIZE AND DIRECT THE ATTENDING PHYSICIANS (OR DENTIST) ON SUITY TO PERFORM EMERGENCY TREATMENT ON MY CHILD.</p> <p>Parent's Signature: _____ Date: _____</p>
