O **COURT ORDER**
O **MEDICAL ALERT**

Required Emergency Card Information

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

Student's Legal Name: _____ Birthdate: _____ Sex: male female
Last First Middle
Teacher _____ Grade: EC Pre-K 5DAYPK

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: _____

Name:	**Last**	**First**	**Work Phone**	**Hours**	**Cell Phone**	**Other**
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)

Name	**Relationship**	**Address**	**Day Phone**

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).

CONSENT FOR EMERGENCY TREATMENT: (IF IT ISDEEMED NECESSARY BY THE SCHOOL AUTHORITIES, YOUR CHILD WILL BE TAKEN BY AMBULANCE AT THE PARENT'S EXPENSE TO THE NEAREST EMERGENCY FACILITY.

I AUTHORIZE AND DIRECT THE ATTENDING PHYSICIANS (OR DENTIST) ON DUTY TO PERFORM EMERGENCY TREATMENT ON MY CHILD.

Parent's Signature: _____ **Date:** _____

DISASTER RELEASE CARD
Laurelwood Preschool

For Office Use Only

Student Name _____Student ID # _____

Grade Preschool Room ____ Teacher _____ Family ID Number_____

Siblings at the school (Name and Room Number) : _____

_____

In the event of a disaster your student will be released **only to persons** authorized **on this** card. Due to anticipated road damage after a major disaster, it may take many additional hours to reach the school. For this reason, choose individuals who live within walking distance. Be sure these people know (1) that they are authorized to pick up your student and (2) at what point you would expect them to pick-up - immediately or only after hearing from you.

Please Print

Name/Relationship	Daytime Address	Day Phone #	Cell/Pager #
Parent:			
Parent:			

Signature (Parent/Guardian): _____ Date:_____

If telephone service is interrupted, long distance will be the first service restored. Please list an out-of-area contact your family will use.

Person/Relationship: _____ Phone: (____) _____

Address: _____ City, State: _____

List any allergies your student has and/or medications needed: _____

Medication in Nurses Office ☐ Yes ☐ No

Additional Information:_____

****

for staff use only

STUDENT RELEASE

Released to: _____ Identification shown: _____

Destination: _____

Has this person been in contact with parents since disaster? _____

Date/Time: _____ Released by: _____