Roseville Joint Union High School District

Student Emergency Card 2014-2015

PLEASE FILL IN ALL INFORMATION

STUDENT *FULL LEGAL* NAME (AS STATED ON BIRTH CERTIFICATE)

Last Name **First Name** **Middle** **Birthdate** **Sex** **Grade**

Student Address: _____ **Apt.#** ____ **City:** _____ **CA** **Zip code:** _____

Student's Email: _____ **Student Cell Ph:** _____

SCHOOL OF FORMER ATTENDANCE: _____ **City:** _____ **State:** _____ **Phone:** _____

LEGAL Parent/Guardian Information RESPONSIBLE FOR STUDENT

FERPA gives both parents, custodial and noncustodial, equal access to student information unless the school has evidence of a court order or other legal paper that prohibits access to education record, or removes the parent's rights to have knowledge about his or her child's education.

FATHER/Guardian: _____ **Email Address:** _____

Relationship: _____ **Employer:** _____

Lives with: YES☐ NO☐ **Hm Phone:** _____ **Cell Phone:** _____ **Wk Phone:** _____

Address *(if different from Student)*: _____ **Apt. #** _____ **City** _____ **State/Zip** _____

MOTHER/Guardian: _____ **Email Address:** _____

Relationship: _____ **Employer:** _____

Lives with: YES☐ NO☐ **Hm Phone:** _____ **Cell Phone:** _____ **Wk Phone:** _____

Address *(if different from Student)*: _____ **Apt. #** _____ **City** _____ **State/Zip** _____

Additional Parent(s)/Guardian(s) / *also* additional EMERGENCY *LOCAL* contacts to whom your child may be released

Name: _____ **Relationship:** _____ **Lives with: yes☐ no☐**

HmPhone: **Cell:** **Work:**

Name: _____ **Relationship:** _____ **Lives with: yes☐ no☐**

HmPhone: **Cell:** **Work:**

Name: _____ **Relationship:** _____ **Lives with: yes☐ no☐**

HmPhone: **Cell:** **Work:**

Name: _____ **Relationship:** _____ **Lives with: yes☐ no☐**

HmPhone: **Cell:** **Work:**

In the event of an accident or other emergency, I hereby authorize a representative of the school to make such arrangements as he/she considers necessary for my child to receive medical or hospital care, including necessary transportation under such circumstances. I further authorize the physician named below or any licensed physician or surgeon to undertake such care and treatment of my child as he/she considers necessary.

I understand that the RJUHSD does not provide accident medical insurance for students for school-related injuries, but does offer student accident insurance for voluntary purchase. Information about student accident insurance is available in the school office.

Insurance Carrier: _____ **Medical Number: #** _____

Physician Name: _____ **Phone #:** _____

The undersigned hereby agrees to bear all costs incurred as a result of the foregoing, and this authorization will remain in effect until revoked by the undersigned:

_____ **Date** _____ / _____ **Date** _____

***Mother's/Guardian's Signature** ***Father's/Guardian's Signature**

The Education Code 49480 requires parents to inform the school when a student has a continuing medication being taken upon a physician's prescription, and authorizes the school nurse to contact the physician with parental consent. (See No. 3)

Please check the following items if they pertain to your child:

There are no known health problems: ☐

Known eye condition or defect in vision Wear glasses: ☐ Glasses to be worn at all times: ☐

1. Contact lenses ☐ Requires preferential seating ☐ Date of last exam: _____
   If checked, please explain: _____ Physician name: _____ phone: _____
2. **Known hearing problem** Uses hearing aid ☐
   If checked, please explain: _____ Physician name: _____ phone: _____
3. Any condition(s) which teachers need to be aware of such as (please check): **Seizures** ☐ **Fainting Spells** ☐
   Asthma ☐ **Allergies** ☐ **Allergic Reactions to Bee Stings** ☐ **Heart Condition** ☐ **ADD/ADHD** ☐ **Diabetes** ☐
   List **Medication** prescribed: _____ Dosage: For (diagnosis): _____
   Does the drug need to be taken during school hours? Yes ☐ No ☐ *(comments)*: _____ ***(please see NURSE for Addl Form(s)***
   Prescribed by ***Physician name***: _____ phone: _____
4. Has **physical condition** which limits participation in classroom activities: ☐ Physical Education: _____
   If checked, please explain: _____ Physician name: _____ phone: _____

**Information provided on this emergency card may be shared with school personnel if the information is deemed necessary for the health and well-being of the student.*

(Rev. 1-2014)