SMMUSD EMERGENCY CARD 202_ - 202_

Student Emergency Information and Authorization

If you are filling this form out by hand, print all information clearly (no cursive, please).

Grade: ____________

HAVE YOU MOVED? Change of address MUST be verified. Bring a recent gas, water, or electric bill to the Registrar in the Attendance Office.

Student's Last Name | First Name | MI | HOME Phone (Primary) | DAY Phone (Alternate)

Student's Address | City | State | Zip | Student ID Number

Gender ☐ Male ☐ Female | Student's Birthday

Parent 1's Name | Occupation | Parent 1's CELL Phone | Parent 1's WORK Phone

Parent 1's Employer and Employer Address | Parent 1's Email Address

Parent 2's Name | Occupation | Parent 2's Cell Phone | Parent 2's WORK Phone

Parent 2's Employer and Employer Address | Parent 2's Email Address

Custody: Child lives with: ☐ Both Parents ☐ Parent 1 ☐ Parent 2 ☐ Guardian ☐ Other: ____________

☐ Joint Custody, Arrangements (Days): ____________

When BOTH parents plan a temporary absence from the home: NOTIFY THE OFFICE IN WRITING of the name(s) and phone number of adults who will be responsible in the event of an emergency.

EMERGENCY RELEASE: If parents cannot be reached, the school is ONLY authorized to release your child to these LOCAL PERSONS.

	Name	**Relationship**	**Address**	**Phone (Day or Cell)**
1.				
2.				
3.				

IN THE EVENT OF A MEDICAL EMERGENCY, if I cannot be reached, I hereby give consent for my child to be transported to an emergency facility and to receive attention from a physician or dentist.

Name of Insurance/MediCare | Subscriber Number | Group Number | Phone Number

Physician's Name | Address | Phone Number | Date of Last Exam

Dentist Name | Address | Phone Number | Date of Last Exam

IDENTIFY ANY HEALTH PROBLEMS

Allergic to:

Current Medication taken at home or school:

AUTHORIZATION FOR MEDICATION: *Will not be given without your signature.* If left blank or crossed out, medication will NOT be made available to your child. I hereby request that the school nurse make available the following medication(s) to my child as prescribed by the District physician consultant:

Medication (cross out if do NOT want given)	*Dosage (same for either medication)*	*Route/Frequency*	*Parent SIGNATURE* ***Required***
Acetaminophen (Tylenol) - 325mg/tablet	1 tablet (if student weighs less than 100 pounds) 2 tablets (if student weighs 100 pounds or more)	By mouth Every 4-8 Hours	
Ibuprofen (Motrin, Advil) - 200mg/tablet			

PLEASE INITIAL IN THE BOXES BELOW:

☐ I authorize the release of photos and videos of my child for school related media during the school year.

☐ I give consent for the names, addresses, telephone numbers and/or email addresses to be included on a class roster and distributed to other families in my child's class.

Parent or Legal Guardian Signature ____________ **Date** ____________