Santa Barbara Unified SCHOOL DISTRICT

EMERGENCY CARD

Special Health Alert: _____

Student Name: _____ **D.O.B.:** _____ **Grade:** _____ **Sex:** M ☐ F ☐
Last *First*

	Mother/Guardian	Father/Guardian *(Check box if same as mother)*
Name *(Last, First)*		
Address *(Street, City and Zip)*		☐
Home phone #		☐
Employer and phone#		
Additional phone#		
Email		

Child Lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Step Mother ☐ Step Father ☐ Guardian/Other:_____

ALTERNATE CONTACTS

Please list persons **other than the parent/guardian** that the school can reach should your child need medical treatment for illness or injury. **Please complete all 4 contacts below.**

Name	Phone number	Relationship to student
1.		
2.		
3.		

In addition, please list an out-of-state person and phone number in case of a disaster:

4.		

In case of disaster (check one) ☐Keep my child at school OR ☐ Release my child to any of the people listed

	Siblings	**School**
Student's physician:		
Last physical exam:		
Insurance company:		

MEDICAL INFORMATION

Check only those that apply and return to school office

☐ **No medical concerns**

☐ **Asthma** Requires medication/inhaler ☐ Yes ☐ No ☐ Daily ☐ As needed ☐ With exercise
Name of medication _____ Given at school? ☐ Yes ☐ No

☐ **Allergic reactions (severe)** To what? _____Hives/rash ☐ Yes ☐ No Breathing difficulty? ☐ Yes ☐ No
Uses Benadryl ☐ Yes ☐ No Has epi-pen? ☐ Yes ☐ No

☐ **Diabetes** ☐ Type I ☐ Type II Medications: ☐ Oral ☐ Injection ☐ Pump
Given at school? ☐ Yes ☐ No

☐ **Seizure disorder** Date of last seizure _____ Requires medication? ☐ Yes ☐ No
Name of medication _____ Physician _____

☐ **Heart problems** Diagnosis: _____ Physical restrictions ☐ Yes ☐ No

☐ **Hospitalization (ER visits)** Date/Explain: _____

☐ **Assistive Devices** ☐ Corrective shoes/braces ☐ Crutches ☐ Wheelchair/scooter ☐ Glasses ☐ Hearing aides

☐ **Taking Medication** For what condition: _____
Given at school? ☐ Yes ☐ No

Please list any other important health information: _____

If my child suffers a serious injury or illness, I understand first aid will be rendered in accordance with local school practices. If neither my alternate nor I can be reached by phone, please call the doctor listed or transport my child to any available medical facility. I am aware that in most situations the physical/medical facility will not treat a minor child without parent permission. I understand that the school assumes no financial responsibility for medical care or transportation.

Signature: _____ **Date:** _____

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