

San Francisco Unified School District Date: _____
*** 2018-2019 * STUDENT EMERGENCY / MEDICAL INFORMATION CARD**
(This card needs to be completed every school year)

NAME: _____ HO#: _____
(Last) (First) (Middle Initial)

School: **ALAMO ELEMENTARY SCHOOL** Grade: _____ Age: _____ Home Room: _____

Birthdate:

MONTH			DAY			YEAR			

 Sex: M F Non

Home Address: _____ Apt. No: _____ City: _____

Zip Code: _____ Home Phone: _____ Language Spoken at Home: _____

Parent/Guardian/Caregiver Name:		Parent/Guardian/Caregiver Name:	
Home Address:		Home Address:	
Employer:		Employer:	
Home Phone:	Work Phone:	Home Phone:	Work Phone:
Cell Phone:	email Address:	Cell Phone:	email Address:

CHILD LIVES WITH: Mother Father Caregiver/Guardian Other (specify) _____

EMERGENCY CONTACTS: In the event that there is an emergency or the child listed above becomes ill or is injured at school ***and I cannot be contacted***, the school authorities have my permission to contact and release my child to the custody of one of the following:

#	Name	Relationship	Home Phone	Cell Phone
1.				
2.				
3.				

My child has health insurance: Yes No If YES, list name of coverage: _____ Policy/Member#: _____

Health Care Provide/Doctor: _____ Telephone: _____

To assure prompt attention to your child **PLEASE NOTIFY SCHOOL OF ANY CHANGES OF INFORMATION ON THIS CARD.**

***** IMPORTANT: Please Complete ALL Items Below. *****

NO MEDICAL CONDITION **My child has been diagnosed with the following condition(s):**
 Asthma Seizures Diabetes **Insulin required?** Yes No Allergies **Requires Epinephrine?** YES NO

Allergies/Allergic to: _____ Date of last reaction: _____

Does your child have any other major health issue(s)? Yes (please list) No

1. _____ 2. _____

Is your child taking medication(s)? Yes (please list medication and times taken) No

Medication: _____ Time Taken: _____

Medication: _____ Time Taken: _____

Other children attending SFUSD schools:

Name	School	Grade

<p>If my child needs to be taken to an emergency facility, he/she will be taken to the nearest one. I give my consent for school authorities to take appropriate action for the safety and welfare of my child.</p>	<p>I do not consent <input type="checkbox"/></p>
<p>Like many school districts in California, SFUSD, in cooperation with the California Department of Health Care Services, participates in a program that allows the District to be reimbursed with federal dollars for selected health services provided to students at school who are eligible for Medi-Cal. This program generates funds that support some staff cost and some equipment needed to provided services. In signing, you are indicating that we have your consent to seek reimbursement from the State for Medi-Cal benefits on behalf of your child, if your child is eligible for this program or becomes eligible. There is no cost or penalty to you if you consent to this, nor if you do not consent to it. It simply gives the school district the right to access to additional governmental supports.</p> <p>I give consent for SFUSD to release information (e.g. Student ID number, Last Name, First Name, Date of Birth, Sex, Student Address, School Site, Grade, Special Ed information (IEP/IFSP)) about my child's participation in health assessments (e.g. Health/Nutrition, Psychosocial status, Health Education/Anticipatory Guidance, Hearing, Vision, Developmental) for the sole purpose of Medi-Cal billing</p>	<p>I do not consent <input type="checkbox"/></p>

To the best of my knowledge all information that I have provided on this Emergency Card is true and accurate. I agree to the statements of consent above, unless my consent has been specifically withheld as indicated by a checked box.

Date: _____

Parent's/Guardian's Signature _____