

## ANNUAL STUDENT EMERGENCY INFORMATION

STUDENT NUMBER	FIRST NAME	MIDDLE INIT	LAST NAME	NICKNAME	SEX	
<b>CURRENT</b>	SCHOOL <b>PIONEER</b>		BIRTHDATE	CLASS	E-MAIL ADDRESS	
HOME ADDRESS		CITY, STATE, ZIP		HOME TELEPHONE NUMBER		
MAILING ADDRESS		CITY, STATE, ZIP		CELL NUMBER (Primary Contact)		
CHILD RESIDES WITH:		<input type="checkbox"/> BOTH PARENTS	<input type="checkbox"/> MOTHER ONLY	<input type="checkbox"/> FATHER ONLY	<input type="checkbox"/> LEGAL GUARDIAN	<input type="checkbox"/> OTHER - PLEASE EXPLAIN
LANGUAGE SPOKEN AT HOME		I REQUEST WRITTEN MATERIAL IN:				
		<input type="checkbox"/> ENGLISH	<input type="checkbox"/> SPANISH	<input type="checkbox"/> VIETNAMESE	<input type="checkbox"/>	
PARENT/GUARDIAN NAME: LAST, FIRST MIDDLE INIT		EMPLOYER		TELEPHONE NO & EXT		
SPOUSE/GUARDIAN NAME: LAST, FIRST MIDDLE INIT		EMPLOYER		TELEPHONE NO & EXT		
CHILD CARE PROVIDER		TELEPHONE				
ADDRESS		DAYS/HOURS		RELATIONSHIP		

### EMERGENCY INFORMATION

If my child needs to leave school because of illness, accident or an emergency and I cannot be reached, the school may call/release my child to the Child Care Provider or to the following: PLEASE SELECT A PERSON WHO WILL BE ABLE TO PICK UP YOUR CHILD DURING THE DAY.

NAME	RELATIONSHIP	TELEPHONE NUMBER

IN AN EMERGENCY, IF THE SCHOOL IS UNABLE TO REACH ME, I HEREBY GIVE MY CONSENT FOR TREATMENT TO BE GIVEN BY:

DOCTOR'S NAME	TELEPHONE NUMBER	INSURANCE COMPANY
DENTIST'S NAME	TELEPHONE NUMBER	
		POLICY NUMBER

### MEDICAL INFORMATION IF "YES" PLEASE PLACE "X" IN BOX

ON MEDICATION <input type="checkbox"/>	MEDICATION ALLERGY <input type="checkbox"/>	HEARING PROBLEM <input type="checkbox"/>	VISION PROBLEM <input type="checkbox"/>
CONTACT LENSES <input type="checkbox"/>	LIMITED ACTIVITY <input type="checkbox"/>	SEIZURE DISORDER <input type="checkbox"/>	HEART PROBLEM <input type="checkbox"/>
DIABETES <input type="checkbox"/>	ASTHMA <input type="checkbox"/>	ALLERGY/BEE STING <input type="checkbox"/>	ALLERGY/OTHER <input type="checkbox"/>

IF ANY OF THE ABOVE ARE CHECKED OR YOU HAVE ANY MEDICAL INFORMATION THE SCHOOL SHOULD BE AWARE OF, PLEASE EXPLAIN:

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### IN THE EVENT OF A DISASTER, MY CHILD CAN BE RELEASE TO THE FOLLOWING PEOPLE:

NAME	RELATIONSHIP	TELEPHONE NO.	DESTINATION (OFFICE USE ONLY)
NAME	RELATIONSHIP	TELEPHONE NO.	
NAME	RELATIONSHIP	TELEPHONE NO.	

IF THE PARENT CANNOT BE REACHED, AND IT IS DETERMINED MY CHLD NEEDS EMERGENCY MEDICAL CARE, PLEASE TAKE MY CHILD TO THE NEAREST EMERGENCY AID STATION BY AMBULANCE. IF NECESSARY FOR TREATMENT.

I REALIZE THAT THE SHOOOL DISTRICT CANNOT ASSUME RESPONSIBILITY FOR THE PAYMENT OF MEDICAL EXPENSES INCURRED.

### SIGNATURES:

LEGAL GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_ STUDENT \_\_\_\_\_ DATE \_\_\_\_\_

### SIGNATURES:

SPOUSE/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

PARENTS/GUARDIAN: Please complete this form and return to the student's school.