# SAN DIEGUITO UNION HIGH SCHOOL DISTRICT
## EMERGENCY FORM

The following information is necessary for the Student Health Record.
Please complete this form, **sign** and **return** to your school annually. This is not a "change of residency" form.
* **If you have changed your residence, please complete and submit a "Verification of Residency Form"** available at your student's school registrar's office.

☐ Male ☐ Female ____________ ID# ____________

**STUDENT: Last Name** | **First Name** | Initial | Date of Birth Month/Day/ Year | Student Identification

Address Where the **Student Resides Currently** Apartment # City Zip Code | School | Grade

**Please check which Parent/Guardian should be contacted first**:

**FATHER** ____

**Father's Name** (**Please indicate**: Father/Guardian/Tutor)

Home Phone # Cell #

Place of Employment /Department Work Phone #

Father's E-mail Address

Father's Current Address **Is This New Address?** No ☐ ***Yes** ☐

Mailing Address *(If different than above)*

Father's Years of Education: ________ (# of years) Language ____________

**Father** needs interpreter for phone calls and meetings: **NO** ☐ **YES** ☐

**MOTHER** ____

**Mother's Name** (**Please indicate**: Mother/Guardian/Tutor)

Home Phone # Cell #

Place of Employment /Department Work Phone #

Mother's E-mail Address

Mother's Current Address **Is This a New Address?** No ☐ ***Yes** ☐

Mailing Address *(If different than above)*

Mother's Years of Education: ________ (# of years) Language ____________

**Mother** needs interpreter for phone calls and meetings: **NO** ☐ **YES** ☐

**ADDITIONAL CONTACTS:** **CONTACTS MUST BE LOCAL -** List contacts for **two adults** other than parent/guardian.
If parent/guardian cannot be reached, we authorize the school staff to release the student to:

1) Local Contact: ____________________
**Adult's Full Name** | Relationship to Student | Home / Work Number | Cell Number

2) Local Contact: ____________________
**Adult's Full Name** | Relationship to Student | Home / Work Number | Cell Number

**MEDICAL INFORMATION: EC §49423**

Name of Student's Physician/Clinic: ____________________
Name | Address | Phone # Physician/Clinic

**I give my consent** for school personnel to communicate with my son/daughter's physician NO ☐ **YES** ☐

Does the student take continuing medication: NO ☐ YES ☐
Will it be necessary to take medication at school? NO ☐ YES ☐

**If student requires administration of medication during school hours,** parent must **complete** and deliver to the school's Health Office the **"Authorization for Administration of Medication" form signed by parent and physician.** The form is available at: http://www.sduhsd.net/downloads/

**EMERGENCY: In an emergency, I give my consent: For family physician, EMT and/or hospital to provide emergency treatment to my son/daughter**: NO ☐ **YES** ☐

Student has medical insurance? NO ☐ YES ☐ Medical insurance in: Father's name ☐ Mother's name ☐

Medical Insurance Carrier | Policy Number / Group | Insurance Contact Number/s

**Signature of Father/Guardian** Date | **Signature of Mother/Guardian** Date

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