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)	By mouth Every 4-8 Hours	
Ibuprofen (Motrin, Advil) - 200mg/tablet	2 tablets (if student weighs 100 pounds or more)		

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** _____