

Year: _____ Grade: _____
 Teacher: _____ ID#: _____

**SAN MARCOS UNIFIED SCHOOL DISTRICT
 STUDENT EMERGENCY CARD**

X _____
 Last Name First Name Middle Name Birthdate

X _____
 Home Address Home Phone Parent E-Mail Address

IN CASE OF AN EMERGENCY, IT IS IMPORTANT FOR THE SAFETY OF YOUR CHILD THAT WE HAVE INFORMATION REQUESTED BELOW.

1. _____
 Name (Parent) Employer Cell Phone Work Phone

2. _____
 Name (Parent) Employer Cell Phone Work Phone

IT IS VERY IMPORTANT, IN CASE PARENTS CANNOT BE REACHED, THAT TWO (2) ADDITIONAL NAMES AND TELEPHONE NUMBERS BE LISTED BELOW:

3. _____
 Alternate Local Contact Name Relationship Phone

4. _____
 Alternate Local Contact Name Relationship Phone

IF NONE OF THE ABOVE IS AVAILABLE, YOUR CHILD WILL BE TRANSPORTED BY AMBULANCE TO THE HOSPITAL.

Siblings in school:

 Name School Grade Name School Grade

 Name School Grade Name School Grade

HEALTH CONDITION(S)- Check all that apply
 IF NO HEALTH PROBLEMS check here
 ADHD
 Asthma, needs Inhaler at school: Yes No
 Diabetes, needs Insulin at school: Yes No
 Heart Problem, explain: _____
 Seizure Disorder, explain: _____
 Known Hearing Loss , wears hearing aide(s): R L
 Vision Problem Wears Glasses Wears Contact Lenses
 Other Health Problem, explain: _____
 History of concussion, date(s): _____

ALLERGIES- Check all that apply
 IF NO KNOWN ALLERGIES check here
 Bee Sting Allergy
 Food Allergy, list foods: _____

 Medication Allergy, explain: _____
 Other Allergy, explain: _____
 Check here if your child has had an Anaphylactic Reaction
 Does your child require medication to treat allergies: Yes No
IF MEDICATIONS ARE REQUIRED TO TREAT AN ALLERGIC REACTION, PLEASE CONTACT THE SCHOOL HEALTH OFFICE OR CHECK THE SCHOOL WEB SITE TO OBTAIN THE REQUIRED FORMS.

MEDICATION(S)- List medications below. IF NONE, Check Here
 Medication name/dose/time taken: _____
 Are any of the listed medications taken at school? Yes No
IF MEDICATIONS ARE REQUIRED AT SCHOOL, A SIGNED PARENT PERMISSION FORM AND PHYSICIANS ORDER IS REQUIRED. PLEASE CONTACT THE SCHOOL HEALTH OFFICE OR CHECK THE SCHOOL WEB SITE TO OBTAIN THE REQUIRED FORMS.

MEDICAL CARE PROVIDER PHONE NUMBERS-
 Physician Name/Phone: _____ Dentist Name/Phone: _____
 Does your child have Health Insurance? Yes No Name of Insurance Provider: _____

**THE HEALTH INFORMATION PROVIDED IN THIS FORM MAY BE SHARED WITH APPROPRIATE SCHOOL PERSONNEL ON A NEED-TO-KNOW BASIS IN ORDER TO PROVIDE FOR YOUR CHILD'S SAFETY AND WELL-BEING.
 PLEASE CONTACT THE SCHOOL NURSE WITH ANY CONCERNS OR QUESTIONS IN THIS REGARD.**

Signature(s) of Parent(s) or Guardian(s): _____ Date: _____
I hereby certify the above information to be true and correct to the best of my knowledge.