	Office Use Only CSIS # Date Enrolled				
parent or guardian	. Please check th	ne data carefully, ma	be able to reach the stu ake corrections, and fill ly and legibly in ink.		MEDICAL CUSTODY SPECIAL NEEDS
Last Name	First	Middle	Teacher/Advisor	Grade	
Home Address (Primary Residence)	City	State/Zip	Home Phone Gender	Birthdate	Birthplace
Mailing Address, if different from above	City	State/Zip			ardian 1 Parent/Guardian 2 ease contact the School Office.
ARENT/GUARDIAN 1 , Last Name	First	Relation	Email		_ Employer
Home Address	City	State/Zip	Home Phone	Work Phone	Cell Phone

Email

🗆 No

Name

2.

Home Phone

First Name:

Teacher:

Are there any COURT-MANDATED custody/visitation orders limiting access to this student? Other children at home:

STUDE

PAREN

Languages spoken at home: 1. _____

PARENT/GUARDIAN 2

Home Address

Last Name

Name

First

Citv

|____|_ Grade

AUTHORIZED CONTACTS Please list the names of relatives/neighbors/friends in close proximity to the school to whom we may release your child or contact if you cannot be reached. NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PARENTS, GUARDIANS OR ADULTS LISTED ON THIS CARD. In selecting someone to whom you authorize the release of your child, consider: (a) Would your child feel safe and comfortable with this person and family?

(b) Could this person care for your child for several days? (c) Is this person prepared to handle any special medical needs required by your child?

School

Relation

State/Zip

I/we hereby authorize the release of the student named above to the following persons in the event of illness, injury, evacuation or emergency that may occur while students are in school.

Name	Relationship	Home Phone	Work or Cell Phone
Call 1 st			
Call 2 nd			
Call 3 rd			
Out-of-state contact:			

I declare that the information on this form is true and correct. I will notify the school office immediately of any changes to be made in the foregoing information.

Parent/Guardian Signature

Date

Relationship

Work Phone

□ Yes If Yes, please attach LEGAL ORDER.

Grade

Employer

Cell Phone

School

STUDENT EMERGENCY CONTACT CARD

Medical Information and Consent

	Middle	
fornia Kids Health Insurance	2	
Phone No.		
Policy No		
Phone No		
reading	lacksquare all the time	
Wears hearing aid(s)		
ur child has ar	ny of the following	
🖵 Benadryl		
licines/Drugs		
on daily medication		
Service Yes No		
	0	
	<u> </u>	
/ide date(s) and	description(s):	
	description(s).	
t school (please	describe):	
	Yes	
school must be Authorization fo	r Administration of	
rate three-day s	upply for the school	
dication" form.	Both forms are	
L	lour(s) given	
r	lour(s) given	
\$		

EMERGENCY TREATMENT AUTHORIZATION

I/we, the undersigned			uardian of do hereby
give authorization an emergency medical co including x-ray exami surgical diagnosis and deemed advisable by general or specific su emergency room staf the Medicine Practice Department of Public	d consent are and ne ination, an d emergend and is to b pervision o f licensed e Act and t	to the scho cessary tro esthetic, r y hospital be rendere of medical under the	bol to obtain ansportation, medical or which is d under the and provisions of
It is understood that the undersigned prior student, but that any be withheld if the un cannot be reached.	effort shal r to render v of the abo	ing treatn ove treatn	nent to the nent will not
		is the	hospital
I/we <u>prefe</u> r for emer my/our child.	gency med	ical treatn	nent of
I/we understand that provide accident/mee and I/we further und to medical treatment responsibility and not	dical insurd erstand th t may be m	ance for st at all cost: y/our	udents, s related
Parent/Guardian Sign	ature		Date
Student Release			
Student Released to:		(print nan	ıe)
		(sign)	
Phone			
Destination			
Date/Time			
			Rev: 09/1

We recommend that you duplicate this card for your records.