# LOS ANGELES UNIFIED SCHOOL DISTRICT
## STUDENT EMERGENCY INFORMATION FORM

*Parent Information: Please fill out completely and sign where indicated. In a major emergency, it is school district policy to retain students at school for their safety. This form will be used by the school staff when students are released to go home. Please complete electronically or print clearly and return completed form to school.*

STUDENT'S LAST NAME | FIRST NAME | M.I.

| STUDENT'S LAST NAME | | FIRST NAME | | M.I. |
|---|---|---|---|---|
| BIRTH DATE | ☐ MALE ☐ FEMALE | GRADE | HOME LANGUAGE | |
| STUDENT'S HOME ADDRESS -- NUMBER | STREET | APT # | CITY | ZIP CODE |
| MAILING ADDRESS -- NUMBER (IF DIFFERENT FROM ABOVE) | STREET | APT # | CITY | ZIP CODE |
| PARENT'S / LEGAL GUARDIAN'S LAST NAME | FIRST NAME | RELATIONSHIP TO STUDENT | | LIVES WITH? ☐ Yes ☐ No |
| WORK ADDRESS -- NUMBER | STREET | CITY | | ZIP CODE |

| CONTACT NUMBERS | | Indicate which phone to call for each message type:* | | | | EMAIL ADDRESS: |
|---|---|---|---|---|---|---|
| HOME | | EMERGENCY | ☐ Home | ☐ Cell | ☐ Work | |
| CELL | | ATTENDANCE | ☐ Home | ☐ Cell | ☐ Work | |
| WORK | | GENERAL INFO | ☐ Home | ☐ Cell | ☐ Work | |

| PARENT'S / LEGAL GUARDIAN'S LAST NAME | FIRST NAME | RELATIONSHIP TO STUDENT | LIVES WITH? ☐ Yes ☐ No |
|---|---|---|---|
| WORK ADDRESS -- NUMBER | STREET | CITY | ZIP CODE |

| CONTACT NUMBERS | | Indicate which phone to call for each message type:* | | | | EMAIL ADDRESS: |
|---|---|---|---|---|---|---|
| HOME | | EMERGENCY | ☐ Home | ☐ Cell | ☐ Work | |
| CELL | | ATTENDANCE | ☐ Home | ☐ Cell | ☐ Work | |
| WORK | | GENERAL INFO | ☐ Home | ☐ Cell | ☐ Work | |

*To the principal: In case you are unable to reach me during any emergency, you are authorized to contact and, if necessary, release my child to any of the following:*

FIRST NAME

| NAME | RELATIONSHIP | HOME PHONE | CELL PHONE | WORK PHONE |
|---|---|---|---|---|
| NAME | RELATIONSHIP | HOME PHONE | CELL PHONE | WORK PHONE |
| NAME | RELATIONSHIP | HOME PHONE | CELL PHONE | WORK PHONE |

*List any other family members attending this school:*

| LAST NAME | FIRST NAME | HOME ROOM | GRADE | RELATIONSHIP |
|---|---|---|---|---|
| LAST NAME | FIRST NAME | HOME ROOM | GRADE | RELATIONSHIP |

MIDDLE INITIAL

## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

The undersigned, as parent/legal guardian of, _____ a minor,

*(Print name of the student here)*

hereby authorizes the principal or designee, into whose care the student has been entrusted, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to the student upon the advice of any licensed physician and/or dentist. It is understood that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the Los Angeles Unified School District ("District") to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary. This authorization is given in accordance with Section 49407 of the California Education Code, and shall remain effective until revoked in writing and delivered to the District. I understand that the District, its officers and its employees assume no liability of any nature in relation to the transportation of the student. I further understand that all costs of paramedic transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my sole responsibility as the student's parent/guardian.

HEALTH ALERTS -- *List any medical condition which restricts physical activity or requires special attention. Include conditions such as asthma and allergies such as peanut and bee stings. If none, please indicate "none".*

DOES THE STUDENT HAVE HEALTH INSURANCE? (Check One) ☐ YES ☐ NO* If "Yes": ☐ Private Health Insurance ☐ Medi-Cal ☐ Healthy Families

MEDI-CAL / HEALTHY FAMILIES ID Number:

| 1. PRIVATE HEALTH INSURANCE NAME | GROUP NO. | 2. PRIVATE HEALTH INSURANCE NAME (If covered under more than one plan) | GROUP NO. |
|---|---|---|---|
| NAME OF DOCTOR / MEDICAL OFFICE | | PHONE NUMBER OF DOCTOR / MEDICAL OFFICE | |

*If the student currently does not have health insurance, information on free or low-cost health care programs is available by calling the District's toll-free HELPLINE 1(866)742-2273.

| | |
|---|---|
| MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICATIONS: | |
| MY CHILD CURRENTLY TAKES THE FOLLOWING MEDICATIONS: | |

*I CERTIFY THAT I HAVE READ AND UNDERSTOOD THIS FORM AND DO HEREBY GIVE MY AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT, AND THAT ALL OF THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE AND CORRECT.*

X _____ DATE

SIGNATURE OF: (CHECK ONE) ☐ PARENT ☐ LEGAL GUARDIAN

* Selected telephone number must be a direct dial number (no extensions).

Revised March 2010