SAN MARCOS UNIFIED SCHOOL DISTRICT STUDENT EMERGENCY CARD

Year:	_Grade:
Teacher:	ID#:

x						
Last Name	First Name		Middle Name	e Birthda	Birthdate	
X						
Home Address			Home Phone	Parent E-Mail /	Address	
IN CASE OF AN EMERGENC	Y, IT IS IMPORTANT F	OR THE SAFETY	OF YOUR CHILD THAT WE HA	VE INFORMATION REQU	ESTED BELOW.	
1.						
Name (Parent)	Em	ployer	Cell Phone Work Phone		9	
2						
Name (Parent)	Em	ployer	Cell Phone	Work Phone	9	
IT IS VERY IMPORTANT, IN CA	SE PARENTS CANNOT B	REACHED, THAT	TWO (2) ADDITIONAL NAMES A	ND TELEPHONE NUMBERS E	SE LISTED BELOW	
3						
Alternate Local Contact N	ame	Re	elationship	Phone	Phone	
4.						
Alternate Local Contact N	ame	Re	elationship	Phone		
IF NONE OF THE ABOVE IS	AVAILABLE, YOUR CH	ILD WILL BE TRA	NSPORTED BY AMBULANCE 1	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			ALLERGIES- Check all that apply			
IF NO HEALTH PROBLEMS check here \square			IF NO KNOWN ALLERGIES check here \square			
□ ADHD			☐ Bee Sting Allergy			
☐ Asthma, needs Inhaler at school: ☐Yes ☐No			☐ Food Allergy, list foods:			
Diabetes, needs Insulin a				nin.		
Heart Problem, explain:			☐ Medication Allergy, explain: ☐ Other Allergy, explain:			
☐ Seizure Disorder, explain: ☐ Known Hearing Loss , wears hearing aide(s): ☐ R ☐ L			☐ Check here if your child has had an Anaphylactic Reaction			
☐ Vision Problem ☐ Wears Glasses ☐ Wears Contact Lenses			Does your child require medication to treat allergies: \square Yes \square No			
☐ Other Health Problem, explain:		IF MEDICATIONS ARE REQUIRED 1	TO TREAT AN ALLERGIC REACTION	ON, PLEASE		
History of concussion, date(s):		CONTACT THE SCHOOL HEALTH OF OBTAIN THE REQUIRED FORMS.	FFICE OR CHECK THE SCHOOL W	IER SHE 10		
MEDICATION(S)- List medic Medication name/dose/tim		E, Check Here	1			
Are any of the listed medica		? □Yes □No				
			ERMISSION FORM AND PHYSI	CIANS ORDER IS REQUIRE	D. PLEASE	
CONTACT THE SCHOOL HEA	LTH OFFICE OR CHEC	THE SCHOOL W	EB SITE TO OBTAIN THE REQU	JIRED FORMS.		
MEDICAL CARE PROVIDER	PHONE NUMBERS-					
Physician Name/Phone:		—				
Does your child have Health	i Insurance? □Yes I	■No Name of I	nsurance Provider:			
KNOW BASIS IN ORDER TO	PROVIDE FOR YOUR	CHILD'S SAFETY	HARED WITH APPROPRIATE S AND WELL-BEING. QUESTIONS IN THIS REGARD		A NEED-TO-	

I hereby certify the above information to be true and correct to the best of my knowledge.

Signature(s) of Parent(s) or Guardian(s):____

Date: