Office Use-Medical Alert**:** ______________________________

# DAILEY ELEMENTARY EMERGENCY CARD

**COURT ORDERS:** □ Yes □ No **COPIES** □ Yes □ No □ N/A **GRADE:** ________ **BIRTHDATE:** ________ / ________ / ________ **ROOM:** ______________

**STUDENT:** ________________________________________ ________________________________________ **Preferred Name**: ___________________________________
Last First

**Primary Residence of Student:** ______________________________________________________________________________________________________
House Number Street Name Apt # City Zip Code

**Male** _____ **Female** ____ **Preferred Pronoun(s**): __________________ Daycare Name: _________________________________ Ph: ______________________________
□ M □ T □ W □ Th □ F

*The phone number #1 and email address will be used for school communication (school, grade level, and/or teacher).*

**FIRST CONTACT –** Parent/Legal Guardian: ______________________________________________________ Relationship: ________________________________________

Address**:** ________________________________________________________________________________ Email Address: ______________________________________
House Number Street Name Apt # City Zip Code
□ yahoo.com □ gmail.com □ outlook.com
□ icloud.com □ ______________________

Phone #1**:**_____________________________________ □ Cell □ Work □ Home Phone #2: ____________________________________ □ Cell □ Work □ Home

**SECOND CONTACT –** Parent/Legal Guardian: _____________________________________________________ Relationship: _______________________________________

Address**:** ________________________________________________________________________________ Email Address: ______________________________________
House Number Street Name Apt # City Zip Code
□ yahoo.com □ gmail.com □ outlook.com
□ icloud.com □ ______________________

Phone #1**:**_____________________________________ □ Cell □ Work □ Home Phone #2 : ____________________________________ □ Cell □ Work □ Home

List other siblings attending this school: ________________________________ __________________________________ __________________________________

**EMERGENCY CONTACTS** (Authorized contacts who are able to pick up your student**.** Authorized persons must be 18 years old & provide Identification to Office Staff.)

Name: ________________________________ Relationship: ________________________ Phone: ______________________

Name: ________________________________ Relationship: ________________________ Phone: ______________________

Name: ________________________________ Relationship: ________________________ Phone: ______________________

**MEDICAL INFORMATION:** This student has the following health condition(s). Check all that apply to this student:

| | | | | | |
|---|---|---|---|---|---|
| □Vision Difficulty | □Asthma | □Catheterization/ G Tube Feeding | □Medication Allergies | □Serious Illness | □Glasses |
| □Bleeder | □Allergies | | □Serious Accident | □Nose Bleeds | □Hearing Difficulty |
| □Contacts | □Diabetes | □Seizure Disorder | □P.E. Excuse (Doctor) | □Medical Excuse | □Bee Sting Allergy |
| □Hearing Aid | □Heart Condition | □Tuberculosis | □Other: ____________________ | | |
| □Peanut Allergy* | □Food Allergy* ________________ | | ***Peanut & Food Allergies: complete a Special Meal Accommodation form*** | | |

**EXPLAIN items checked:** ____________________________________________________________________________

**EMERGENCY PROCEDURES:** If an emergency should arise which requires immediate medical attention and we, as parents/guardians cannot be contacted, you are authorized to take whatever steps are needed to protect the health of this student. □ **Yes** □ **No**

Family Doctor: ________________________ Phone: ____________________ Health Plan: ________________________

**MEDICATION AT SCHOOL:** The parent/guardian of any public school pupil on a continuing medication regimen for a non-episodic condition shall inform the Office Manager or other designated school employee of the medication being taken, dosage, and name of the supervising physician. CA Ed Code 12020

*If medication at school is necessary, a written statement from a physician and parent authorization (signature) is required stating the method, dose, and time schedule by which such medication is to be given (Education Code 49423)This pertains to prescription & over the counter medication. The medication MUST have the pharmacy label attached to the medication. Students cannot carry and administer medication themselves.*

Name of Medication: ____________________________ Dosage: ____________________________

Supervising Physician: ___________________________ Phone: _____________________________

**EMERGENCY DISMISSAL PROCEDURES:** In case of a declared emergency by the Executive Director and/or Designee during school hours, all students will be required to remain at school or at an alternate safe site under the supervision of school staff until a safe dismissal time is determined or until an authorized adult picks up the student.

I understand that if emergency medical or dental treatment is needed and the listed emergency contacts cannot be reached, 911 will be called. I realize the school cannot assume responsibility for the payment of medical fees for expenses incurred. I also agree that the principal/designee may transport my child between school and home when, in his/her discretion, it is deemed necessary.

**PARENT/GUARDIAN SIGNATURE:** _______________________________________________ **DATE:** __________________________