

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:

- | | | | | | |
|--|--|---|--|--|---|
| <input type="checkbox"/> Vision Difficulty | <input type="checkbox"/> Asthma | <input type="checkbox"/> Catheterization/
G Tube Feeding | <input type="checkbox"/> Medication Allergies | <input type="checkbox"/> Serious Illness | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Bleeder | <input type="checkbox"/> Allergies | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Serious Accident | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Hearing Difficulty |
| <input type="checkbox"/> Contacts | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> P.E. Excuse (Doctor) | <input type="checkbox"/> Medical Excuse | <input type="checkbox"/> Bee Sting Allergy |
| <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Heart Condition | | <input type="checkbox"/> Other: _____ | | |
| <input type="checkbox"/> Peanut Allergy* | <input type="checkbox"/> 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:** _____