



# EMERGENCY INFORMATION

Amador County Unified School District  
PLEASE PRINT ALL ITEMS

FOR SCHOOL USE ONLY	Grade _____
Teacher _____	Room# _____

Home phone: \_\_\_\_\_

Student's full legal name \_\_\_\_\_  
Last First Middle

Birth Date: (month/day/year) \_\_\_\_\_  Male  Female

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Physical Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Student lives with: Check all applicable  Mother  Father  Stepmother  Stepfather  Grandparents  Other \_\_\_\_\_

If parents are divorced or separated, to whom has the court granted physical custody? (provide verification) \_\_\_\_\_

Mother or Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ City \_\_\_\_\_ Work Phone \_\_\_\_\_

Father or Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ City \_\_\_\_\_ Work Phone \_\_\_\_\_

Parent / Guardian email address \_\_\_\_\_

**Local Emergency Contacts.** If my child is ill, has an emergency, or is suspended and I cannot be reached, please call and release my child to:  
Only persons listed below will be allowed to take child from school without prior parent permission.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### Other Children in the Family Living at Home

Name	Birthdate	School

### HEALTH INFORMATION

I understand that ACUSD/ACOE does not provide accidental medical insurance for students for school related injuries but does offer accident insurance for voluntary purchase. Please see school office for information.

Name of Medical Insurance \_\_\_\_\_ Physician's Name \_\_\_\_\_

1. Is there any health information regarding your student that you would like to share with school staff?  No  Yes

If yes, please explain \_\_\_\_\_ Does this condition require medication?  No  Yes

2. Does your student have any food/or other allergies that would require immediate medical attention?  No  Yes

If yes, please explain \_\_\_\_\_ Does this condition require medication?  No  Yes

3. Is student taking ongoing prescribed medication at home or school?\*  No  Yes What is it? \_\_\_\_\_

What time is it taken? \_\_\_\_\_

\*A written doctor's authorization and parent request must accompany all prescriptions and over-the-counter medications given at school.

**I give consent to the release of health information to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.** In the event of an emergency, when a parent or guardian is unavailable, I authorize school personnel to make arrangements for my child to receive medical/hospital care, including necessary transportation, in accordance with their best judgment. I authorize the physician named above to undertake such care and treatment as is considered necessary. In the event said physician is unavailable, I authorize such care and treatment to be performed by a licensed physician or surgeon.

SIGNATURE Of Parent/Guardian \_\_\_\_\_

DATE \_\_\_\_\_

THIS INFORMATION WILL BE USED IN CASE OF AN EMERGENCY OR ILLNESS.

IT IS YOUR REponsibility TO NOTIFY THE SCHOOL OF ANY CHANGES IN THE INFORMATION GIVEN ABOVE!