EMERGENCY AUTHORIZATION

TO BE FILLED OUT BY PARENT(S) OR LEGAL GUARDIAN(S)

please print in blue/black ink

Completed card must be returned in order to complete registration

☐ MALE ☐ FEMALE ☐ NON BINARY **Grade** _____ **Room #** _____ **Student ID #**_____

STUDENT INFORMATION: _____ **BIRTHDATE**_____

Last Name First Name Middle Initial

Home Address: _____ **City** _____ **Zip Code**_____ **Home Phone #**_____

DO YOU HAVE COURT-ORDERED CHILD CUSTODY PAPERWORK, SCHOOL DAY DROP-OFF/PICK UP AGREEMENTS OR RESTRAINING ORDER? ____YES ____ NO
IF YES, PLEASE GIVE A COPY TO THE SCHOOL OFFICE MANAGER

NAME OF PARENT	EMPLOYER/MILITARY COMMAND	WORK PHONE	CELL PHONE	LIVES W/ STUDENT	MAY WE CONTACT YOU WITH TEXT MESSAGES?
PARENT/GUARDIAN Email:				☐YES ☐NO	☐YES ☐NO
PARENT/GUARDIAN Email:				☐YES ☐NO	☐YES ☐NO

IF WE/I CANNOT BE REACHED, AN AUTHORIZED SCHOOL OFFICIAL MAY CALL THE FOLLOWING REALTIVE(S) OR FRIEND(S) WHO WILL TAKE RESPONSIBILITY FOR MY CHILD'S CARE

1. NAME:_____ **PHONE #**_____ **2. NAME:**_____ **PHONE #**_____

In the event the parent/guardian cannot be contacted, the school reserves the right to act in place of the parent(s)/guardian(s)

Signature of Parent/Guardian _____ **Date:**_____

In compliance with State Education Code 12020:

DOES YOUR CHILD RECEIVE MEDICATION DAILY _____ YES _____ NO

If your child does use any medication daily, please state:

NAME OF MEDICINE: _____

DATE STARTED:_____ **DOCTOR:**_____ **PHONE #**_____

●*In an emergency, may a school official call the above named Physician regarding this student, if parent or guardian cannot be contacted?* ☐ YES ☐ NO

●**May we contact any Licensed Physician if your physician is not available?** ☐ YES ☐ NO

●May the School Nurse communicate regarding his/her care? ☐ YES ☐ NO

Physical Education is a state requirement, and restrictions require a Physician's statement. List any serious illnesses or accidents that could interfere with physical education activities:_____

CONDITION If student has any of the listed, please "X"		DATE	CONDITION If student has any of the listed, please "X"		DATE
Wears Glasses			Allergies		
Frequent Headaches			Orthopedic Condition		
Hearing Impairment			Allergy to Bee Stings		
Epilepsy or Convulsion			Heart Condition		
Diabetes			Asthma		
Surgical Operations			Please Explain		
OTHER CONDITION: (Please explain)					

Hueneme Elementary School District submits claims to Medi-Cal for basic health screenings and services given to all students. Revenues received help to provide additional health services for all district students**. Parents will not be asked to pay for any school health services.**

I consent for billing to Medi-Cal/Insurance carriers for school health services provided for my child and for exchange of billing information with the school district's billing services company.

PLEASE INITIAL _____ YES _____ NO

Parent/Legal Guardian Signature:_____ **Date:**_____