

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:

Last Name _____

First Name _____

Middle Initial _____

BIRTHDATE _____

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				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Email: _____					
PARENT/GUARDIAN				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Email: _____					

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: _____