EMERGENCY INFORMATION

Amador County Unified School District
PLEASE PRINT ALL ITEMS

Date_______________

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 REPONISBILITY TO NOTIFY THE SCHOOL OF ANY CHANGES IN THE INFORMATION GIVEN ABOVE!