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:

□ None	□ Asthma	□ Catheterization/ G Tube Feeding	□ Medication Allergies	□ Serious Illness	□ Glasses
□ Bleeder	□ Allergies	□ Seizure Disorder	□ Serious Accident	□ Nose Bleeds	□ Hearing Difficulty
□ Contacts	□ Diabetes	□ Tuberculosis	□ P.E. Excuse (Doctor)	□ Medical Excuse	□ Bee Sting Allergy
□ Hearing Aid	□ Heart Condition		□ Other: ______________________		
□ Vision Difficulty	□ Peanut Allergy*	□ Food Allergy* ______________________			

Peanut & Food Allergies: complete a Special Meal Accommodation form

EXPLAIN items checked: ____

EMERGENCY PROCEDURES: □ Yes □ No 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.

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:** ______________________