SANTA CRUZ VALLEY UNIFIED SCHOOL DISTRICT #35

Student Medical / Emergency Information Record

MEDICAL ALERT_____

Student's Last Name	Student's First Name	Birth Date	☐ Male ☐ Female
Student's Physical Address			

Mother/Guardian	Cell Phone #	Work Phone #	Employer
Father/Guardian	Cell Phone #	Work Phone #	Employer

Who does child live with? ☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Guardian ☐ Other: _____

List local family or friends who can be contacted to pick up student in case of emergency if parents are not available:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Student's Doctor: _____ Phone: _____

Does your child have any of the following health conditions or allergies? (Please speak with the health office regarding health conditions)

YES NO

☐ ☐ Asthma Uses inhaler? ☐ Yes ☐ No
☐ ☐ Diabetes ☐ Type I ☐ Type II
☐ ☐ Seizure Disorder
☐ ☐ Heart Condition ☐ Pacemaker
☐ ☐ Bleeding Disorder
☐ ☐ Kidney Disease
☐ ☐ Gastrointestinal Disorder
☐ ☐ Migraines/Headaches
☐ ☐ ADHD (Attention Deficit Hyperactivity Disorder)
☐ ☐ Allergies to medication, food, seasonal, insect bites, other: _____
☐ ☐ Has Epi-Pen for Anaphylactic Allergy Self Carry? ☐ Yes ☐ No
☐ ☐ Takes prescribed medications regularly? Please List: _____
☐ ☐ Will medication be administered at school? _____
☐ ☐ Other Medical Condition: _____

Student uses: ☐ Glasses/Contacts ☐ Hearing Device ☐ Walker ☐ Wheel Chair ☐ Other: _____

MEDICATION POLICY: Santa Cruz Valley Unified School District #35 is a "drug free" zone. Students MAY NOT transport medications to/from school or have medications (prescription and/or non-prescription) in their possession at any time. If your child requires medication at school, please pick up a request form in the health office.

Please mark the medications we may provide student if needed:

☐ Saline eye rinse ☐ Orajel ☐ Topical Antibiotics ☐ Topical Analgesic

FOR THE SAFETY AND WELFARE OF MY CHILD, I DO HEREBY AUTHORIZE SCVUSD#35 ADMINISTRATION AND STAFF TO OBTAIN THE NECESSARY EMERGENCY MEDICAL CARE AND TRANSPORTATION TO THE NEAREST HEALTHCARE FACILITY. I UNDERSTAND SCVUSD#35 IS NOT FINANCIALLY RESPONSIBLE FOR ANY EMERGENCY CARE OR TRANSPORTATON OF MY CHILD. **Initials: _____**

I certify that the information on this page is accurate and complete to the best of my knowledge.

Signature of Parent/Guardian: _____ Date: _____

*** * * FOR OFFICIAL USE ONLY * * ***

☐ New Student ☐ Returning Student

School Site: _____ Grade: _____ Student ID: _____ Enter Date: _____

Assigned School: ________________ Date of Enrollment: ________________ Teacher: ____________________ Grade: _______

Changes? ☐ NO ☐ YES: ____

Signature of Parent/Guardian: _______________________________ Date: _______________

Assigned School: ________________ Date of Enrollment: ________________ Teacher: ____________________ Grade: _______

Changes? ☐ NO ☐ YES: ____

Signature of Parent/Guardian: _______________________________ Date: _______________

Assigned School: ________________ Date of Enrollment: ________________ Teacher: ____________________ Grade: _______

Changes? ☐ NO ☐ YES: ____

Signature of Parent/Guardian: _______________________________ Date: _______________

Assigned School: ________________ Date of Enrollment: ________________ Teacher: ____________________ Grade: _______

Changes? ☐ NO ☐ YES: ____

Signature of Parent/Guardian: _______________________________ Date: _______________

Assigned School: ________________ Date of Enrollment: ________________ Teacher: ____________________ Grade: _______

Changes? ☐ NO ☐ YES: ____

Signature of Parent/Guardian: _______________________________ Date: _______________

(Revised 01/2020 CP)