STUDENT EMERGENCY CARD
NURSE'S OFFICE 2019-2020

Student Name _____ grade _____ date of birth _____

Please provide following information for emergency calls:
With whom does child reside: _____ Relation: _____
Mother/Guardian: _____ Address:_____
Phone _____ Employer:_____
Father/Guardian: _____ Address: _____
Phone # _____ Employer: _____

Health Information: List any health conditions, such as asthma, diabetes, heart issues, seizures, severe allergies, ear, eye, stomach, kidney problems, psychiatric or emotional issues, or any other health concerns:

_____
_____
_____
_____

Medication taken regularly and why:

_____
_____
_____

Medication or food allergies: _____
_____
_____

For hospital use only in case we are unable to reach you:

Insurance Co./Policy#: _____ Preferred hospital _____
Health care provider & phone# _____

I, the undersigned, do hereby authorize officials of China Spring ISD to contact directly the persons named on this card, and do authorize the named health care provider to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event health care providers, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of aforesaid child. I will not hold the school district financially responsible for the emergency care, transportation, or outcome in the event that I have failed to provide life-saving medications, supplies, or information needed to treat said child.
. If said child has a diagnosis that could be potentially life-threatening (such as severe allergies, diabetes, asthma, or others) it is the parent's or guardian's responsibility to provide all life-saving medications and proper equipment. If you have not provided the school with the proper medications/equipment/information to treat your child and an emergency occurs, the school will have to obtain emergency medical treatment for your child. The parent/guardian will be responsible for all emergency expenses.

Due to HIPAA (Health Insurance Portability and Accountability Act) laws, in order to pass information along to school employees that need it, we need your signature. I, _____ authorize this health information to be released to school employees that may need it for the appropriate care of my child. I understand I have the right to revoke this authorization, in writing, at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Parent/Guardian signature: _____ date _____