San Juan Unified School District
ASSETs Program 2025-2026

Emergency Form

Students Full Name _____ Birth Date _____

Home Phone _____ Cell Phone _____ Other Phone _____

Address _____

Parents/Guardians student lives with 1._____ 2._____

Mother _____ Circle One: Natural Step Guardian/Foster Other Parent

Employer _____ Business Phone _____

Father _____ Circle One: Natural Step Guardian/Foster Other Parent

Employer _____ Business Phone _____

Emergency Information: If my student is ill or has an emergency and I cannot be reached, please call and release my child to:

Name (two contacts required)	**Telephone**	**Relationship**
_____	_____	_____
_____	_____	_____

Physician's Name: _____ Phone: _____

Medical Coverage: _____ ID#: _____

Parent Must Check One

O 1. In the event of an emergency, when a parent or guardian is unavailable, I authorize school personnel to make arrangements for my student to receive medical/hospital care, including necessary transportation, in accordance with their best judgment. I authorized 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. I agree to pay all costs incurred as a result of the foregoing.

O 2. I do not choose the above statement and desire the following action in the event of an emergency: _____

VISION: ☐ wears glasses ☐ wears contacts ☐ to be worn at all times ☐ requires preferential seating

Date of last eye exam _____ Under care of Dr. _____ Phone _____

HEARING: ☐ has a hearing problem ☐ has tubes in ears ☐ uses hearing aid ☐ requires preferential seating

GENERAL HEALTH: 1. Has the following condition(s): ☐ asthma ☐ epilepsy ☐ fainting spells ☐ diabetes ☐ hyperactive (ADHD) heart condition ☐ migraines ☐ allergies_____ ☐ allergic reaction to bee stings (describe): _____

☐ Other: _____

2. List Medications Prescribed: _____ Current Dosage: _____

For (diagnosis) _____ Prescribed by Dr. _____ Phone _____

3. Has a physical condition which limits participation ☐ no ☐ yes (explain): _____

"I authorize the release of my student medical information 1. by the school district and the provider of services to the billing agent and 2. by the school district to my insurance carrier as necessary to process a claim or to request payment of Medical Assistance Benefits. Shared information will be limited to health service documentation only."

Parent/Guardian Signature _____ Date _____

Print Name _____ Relationship _____