STUDENT'S NAME ❑ MALE ❑ FEMALE Student ID # _____

SOMIS SCHOOL

EMERGENCY CARE AUTHORIZATION

THE FOLLOWING IS TO BE FILLED OUT BY PARENT(S) or LEGAL GUARDIAN(S)

_____
(LAST) (FIRST) (MIDDLE INITIAL)

GRADE_____ **ROOM NUMBER**_____ **BIRTH DATE** _____

Important: promptly report change of contacts, address, phone number, or name of physician.

Must be completed front and back, updated and returned annually. One form per student. Please use black or blue ink.

Home (physical) address:_____

Mailing address (if different from above, PO BOX etc.)_____

NAME	CELL PHONE	EMPLOYER	WORK PHONE	LIVES W/STUDENT	EMAIL ADDRESS
FATHER				YES NO	
MOTHER				YES NO	
GUARDIAN				YES NO	

Do you have court-ordered child custody papers, school day drop-off/pick-up agreements or restraining orders? Yes_____ No_____
********** **IF YES, please give a copy to the school office** **********

EMERGENCY CONTACTS FIRST AND LAST NAME Must be at least 18 years old	RELATIONSHIP TO STUDENT (AUNT, UNCLE, GRANDPARENT, SITTER, FRIEND, ETC.)	CELL PHONE	HOME/WORK PHONE

In the event the above contacts cannot be made, the school reserves the right to act in place of the parents or guardians. IF WE CANNOT BE REACHED, AN AUTHORIZED SCHOOL OFFICIAL MAY CALL THE FOLLOWING FRIEND(S) OR RELATIVE(S) WHO WILL TAKE RESPONSIBILITY FOR MY CHILD'S CARE. **CONTACT INFORMATION IS VERY IMPORTANT TO THE CARE OF YOUR CHILD. IF YOU NEED TO ADD MORE PLEASE ATTACH A SHEET OF PAPER.**

PERMISSIONS/NOTICES OF RIGHTS AND RESPONSIBILITIES: **(Any change requires notification to school in writing.)**

We are now digitizing internal paper forms to reduce excessive paper waste. Please log on to our website at www.somisusd.org to read the following documents or you can come and pick up a hard copy at the school office.

1. I have received and read the "Notice of Parent's Rights and Responsibilities" via the District/School website or as a copy from the school office YES ☐ NO ☐
2. I have received and read the "Student and Parent Handbook" via the District/School website or as a copy from the school office YES ☐ NO ☐
3. I have received and read the "Parent/Student/Teacher Compact" via the District/School website or as a copy from the school office YES ☐ NO ☐
4. I have received and read the "Student Technology Acceptable Use Policy" via the District/School website or as a copy from the school office YES ☐ NO ☐
5. I have received and read the "Library Registration" via the District/School website or as a copy from the school office YES ☐ NO ☐
6. I give permission to have my and my child's name, address, and phone number released to School Organizations YES ☐ NO ☐
7. I give permission to have my child's photographic image(s) appear in the Class Photo and School Yearbook YES ☐ NO ☐
8. I give permission to have my child's photographic image(s) used on the School and/or District Website YES ☐ NO ☐
9. I give permission to have my child's photographic image(s) released to any form of External Public Media (Newspaper, Etc.) YES ☐ NO ☐

HEALTH HISTORY/INFORMATION Check any of the conditions which your child has had. Explain further below in the notes.

CONDITION	Yes	CONDITION	Yes	CONDITION	Yes	CONDITION	Yes	CONDITION	Yes	Serious Allergies	Yes	Special Services	Yes
Vision Impairment		Ear Infections		Frequent Headaches		Diabetes		Heart Condition		Allergic to Bee Stings		Has a Individualized Education Program (IEP)	
Wears Glasses		Asthma		Surgical Operations		Orthopedic Condition		Epilepsy or Convulsions		Has EPI-Pen for Bee Stings?		Has a 504 Plan	
Hearing Impairment		Kidney Problems		Rheumatic Fever		ADHD/ADD		Allergic to Medication(s)		Allergic to Food(s)		Receives Speech Services	
Wears Hearing Aide		Tuberculosis		Hay Fever		Taking Medication for ADHD/ADD		Other Allergies?		Has EPI-Pen for Food Allergies?		Receives Occupational Therapy (OT) Services	

Briefly, Identify/Describe serious information we should know regarding any health problems like allergies, illnesses, physical impairments, medications, accidents, learning difficulties (speech, attention issues) etc...

_____

_____

Does your child receive medication daily: Yes _____ No_____

If your child does use medication daily please Identify/List Medications:_____

Will medications be administered and kept in school office? Yes _____ No_____ (If yes, please pick up a AUTHORIZATION FOR ANY MEDICATION TAKEN DURING SCHOOL HOURS form from the school office and have the doctor complete it before you bring any medication to the school.

Student's Physician:_____Phone:_____

May the school nurse communicate with the student's Physician in order to counsel school personnel as needed regarding his/her care? Yes____ No____

Because physical education is a state requirement, any restrictions require a Physician's statement if there are any serious illnesses or accidents that could interfere with physical education activities.

AUTHORIZATION FOR TREATMENT: In the event of an emergency requiring immediate medical attention, I hereby authorize the Somis Union School District to obtain emergency transportation and treatment on my child's behalf. The undersigned authorizes the hospital to provide appropriate treatment. I understand that every effort shall be made by the hospital to contact the parent or guardian prior to any treatment, but treatment shall not be withheld if the parent or guardian cannot be reached. **I also understand that the Somis Union School District does not assume any financial responsibility for medical care or ambulance transportation.** These authorizations and permissions shall be and remain in full force and effect for the current school year unless revoked in writing. I also understand that I should contact the school immediately if there are any changes in the information contained on this sheet.

Parent/Guardian Signature: _____ **Date:** _____