

EMERGENCY PROCEDURE CARD
Clovis Unified School District

Form 1S
Revised 07/07

****NOTE: This card must be completed and signed by the student's Father, Mother or Guardian****

SID# _____ Grade _____ Room/Counselor _____

STUDENT'S NAME _____ Student's Birthdate _____ Male Female
Last Name First Name Middle Name

HOME ADDRESS _____ Home Phone _____
Street City Zip

E-MAIL ADDRESS _____

IN CASE OF SUDDEN ILLNESS OR ACCIDENT TO THIS STUDENT

1st Contact _____ Home Phone _____ Work Phone _____
Name of Father, Mother or Guardian (please circle one)

_____ Cell Phone/Pager _____
Place of Employment Work Hours

2nd Contact _____ Home Phone _____ Work Phone _____
Name of Father, Mother or Guardian (please circle one)

_____ Cell Phone/Pager _____
Place of Employment Work Hours

3rd Contact _____ Home Phone _____ Work Phone _____ Cell Phone/Pager _____
Name of Step-Father or Step-Mother (please circle one if applicable)

4th Contact _____ Home Phone _____ Work Phone _____ Cell Phone/Pager _____
Name of Other Relative or Neighbor (please circle one)

MEDICAL INFORMATION This student has the following health condition(s): *(Check all that apply to this student.)*

<input type="checkbox"/> Glasses/Contacts	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Epilepsy/Seizure Disorder	<input type="checkbox"/> Medication Allergy	<input type="checkbox"/> Serious Accident
<input type="checkbox"/> Hearing Difficulty	<input type="checkbox"/> Asthma (under Dr. care)	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Food Allergy	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Serious Illness	<input type="checkbox"/> Bleeder	<input type="checkbox"/> Other _____		

School nurse may notify school personnel of medical concerns of any checked (✓) information.

Parent/Guardian signature: _____

CONTINUING MEDICATION REGIMEN FOR NONEPISODIC CONDITION: REQUIRED NOTICE TO SCHOOL EMPLOYEES (Ed. code 49480)

The parent or legal guardian of any public school pupil on a continuing regimen for a nonepisodic condition, shall inform the school nurse or other designated certificated school employee of the medication being taken, the current dosage, and the name of the supervising physician. With the consent of the parent or legal guardian of the pupil, the school nurse may communicate with the physician and may counsel with the school personnel regarding the possible effects of the drug on the child's physical, intellectual, and social behavior, as well as possible behavioral signs and symptoms of adverse side effects, omission, or overdose. The superintendent of each school district shall be responsible for informing parents of all pupils of the requirements of this section.

IF YOUR CHILD IS TAKING MEDICATION REGULARLY, FILL OUT THIS SECTION

My child _____ is taking _____
Name of Child Grade Name of Drug Dosage

ordered by _____ The school nurse may confer with the doctor and notify school personnel regarding the child's condition and the effects of this medication when necessary.
Name of Supervising Physician Telephone Number

▶ **SIGNATURE OF PARENT OR GUARDIAN** _____ **DATE** _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

The undersigned, legal custodian of _____, a minor, hereby authorizes the principal or designee into whose care the aforementioned minor pupil has been entrusted, to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis, treatment, and/or hospital care to be rendered to said minor upon the advice of any licensed physician and/or dentist.

It is understood that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary.

This authorization is given pursuant to the provisions of Section 6910 of the California Family Code, and shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand that the Clovis Unified School District, its officers and its employees assume no liability of any nature in relation to the transportation of the said minor. I further understand that all costs of paramedic transportation, hospitalization, and any examination, x-ray or treatment provided in relation to this authorization shall be borne by the undersigned.

I understand that the Clovis Unified School District does not provide medical or accident insurance for students for school related injuries. I have received and read the student accident insurance information sent home for my child.

I authorize the release of medical information by the school district to its billing agency and to my insurance company as necessary to process a claim or request reimbursement for medical services rendered to my child. Any shared information will be limited to service documentation only. YES NO

Family Physician: _____ Telephone _____ PLEASE CHECK ONE:
Health Insurance/MEDI-CAL: _____ My child is currently insured. I will insure my child.
Group/Policy No./MEDI-CAL ID No.: _____ I choose not to insure my child.

▶ **SIGNATURE OF PARENT OR GUARDIAN** _____ **DATE** _____

The signature on this card of the parent or guardian acknowledge receipt of Notice of Rights of Parents or Guardians of Minor Pupils pursuant to Education Code Section 48980; Board policies regarding Student Records and Sexual Harassment; and of letters regarding Emergency Procedures and Asbestos Management.

Si tiene alguna pregunta o si necesita la ayuda de un interprete, favor de llamar a la oficina de su escuela.
Yog koj muaj lus nug los yog xav tau neeg pab txhais lus, thov hu rau koj lub tsev kawm ntawv.

Revised 03/08