

() Court Order
() Medical Alert

Emergency/Release Information

Student's Legal Last Name _____ First Name _____
Birthdate: _____ Sex: Male/Female Grade: (circle one) 6 7 8

Address _____
Street Unit # City Zip

Home Phone() _____

Language Spoken by child _____ Language spoken by Parent/Guardian _____
Student lives with both parents? Yes or No If no, which parent does student live with: _____

Parent/Guardian (Father) _____
Work Phone() _____ Cell Phone() _____

Parent/Guardian (Mother) _____
Work Phone() _____ Cell Phone() _____

List the persons you authorize to pick up/care for your child in an emergency situation if we are unable to reach you. (Must be 18 years or older)

Name	Work Phone	Cell Phone
	()	()
	()	()
	()	()

Siblings in SCUSD

Name _____ School _____ Grade _____
Name _____ School _____ Grade _____

Doctor _____ Phone # _____ Dentist _____ Phone # _____
Student's Health Insurance _____ I.D. Number _____

The school seeks advice and cooperation of parents and physicians in maintaining the health of pupils. In order that we may know more about your son's/daughter's health, please complete the information below.

Please list your child's health problems, if any. (Examples: diabetes, allergies (including bee sting), asthma, heart problems, bone disease, C.P., etc.)

Vision Difficulties: Yes or No *Contacts/Glasses:* Yes or No *Hearing Difficulties:* Yes or No

Please complete the following section if your child is taking medicine on a continuing basis:

Name of medication _____ Current dosage _____
Reason for medication _____
Name of physician supervising treatment _____ Phone number _____

RE: Medication at School Should it be necessary for your child to take medication at school, you must provide the school with the physician's *written* instructions and your *written* permission. Forms are available in the office.

Prescribed/over the counter medications at school must be kept in the original container. Students are not to have medication in their possession.

CONSENT FOR EMERGENCY TREATMENT: (IF IT IS DEEMED NECESSARY BY THE SCHOOL AUTHORITIES, YOUR CHILD WILL BE TAKEN BY AMBULANCE AT THE PARENT'S EXPENSE TO THE NEAREST EMERGENCY FACILITY. I AUTHORIZE AND DIRECT THE ATTENDING PHYSICIANS (OR DENTIST) ON DUTY TO PERFORM EMERGENCY TREATMENT ON MY CHILD.

Parent signature: _____

Date: _____

CABRILLO MIDDLE SCHOOL DISASTER RELEASE INFORMATION

Student Last Name _____ *First Name* _____
 Student ID # _____ Grade (circle one) 6 7 8
 Siblings at this school (Name and ID #) _____

In the event of a disaster your student will be released *only to persons* authorized in *this* form. Due to anticipated road damage after a major disaster, it may take many additional hours to reach the school. For this reason, choose individuals who live within walking distance. Be sure these persons know (1) that they are authorized to pick up your student, and (2) at what point you would expect them to pick up – immediately or upon hearing from you.

PLEASE PRINT

Name/Relationship	Daytime Address	Day Phone #	Cell #
Parent/Guardian:			
Parent/Guardian:			

If phone service is interrupted, long distance will be the first service restored. Please list an out-of-area contact your family will use.

Person/relationship: _____ Phone : () _____

Address: _____ City, State: _____

List any allergies your student has and/or medications needed: _____

Medication in the Nurse's Office () Yes () No

Additional Information: _____

Signature (Parent/Guardian): _____	Date: _____
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*****FOR STAFF USE ONLY*****

STUDENT RELEASE

Released to: _____ ID shown: _____

Destination to: _____

Has this person been contacted with parent since disaster? _____

Date/Time: _____ Released by: _____