LOS ANGELES UNIFIED SCHOOL DISTRICT
STUDENT EMERGENCY INFORMATION FORM

Parent Information: Please fill out completely and sign where indicated. In a major emergency, it is school district policy to retain students at school for their safety. This form will be used by the school staff when students are released to go home. Please complete electronically or print clearly and return completed form to school.

STUDENT'S LAST NAME	FIRST NAME	M.I.

BIRTH DATE	☐ MALE ☐ FEMALE	GRADE	HOME LANGUAGE

STUDENT'S HOME ADDRESS -- NUMBER	STREET	APT #	CITY	ZIP CODE
MAILING ADDRESS -- NUMBER (IF DIFFERENT FROM ABOVE)	STREET	APT #	CITY	ZIP CODE

PARENT'S / LEGAL GUARDIAN'S LAST NAME	FIRST NAME	RELATIONSHIP TO STUDENT	LIVES WITH? ☐ Yes ☐ No
WORK ADDRESS -- NUMBER	**STREET**	**CITY**	**ZIP CODE**

CONTACT NUMBERS		Indicate which phone to call for each message type:*				EMAIL ADDRESS:
HOME		EMERGENCY	☐ Home	☐ Cell	☐ Work	
CELL		ATTENDANCE	☐ Home	☐ Cell	☐ Work	
WORK		GENERAL INFO	☐ Home	☐ Cell	☐ Work	
TEXT		☐ I authorize receiving text messages and understand that I am responsible for all text related charges.				

PARENT'S / LEGAL GUARDIAN'S LAST NAME	FIRST NAME	RELATIONSHIP TO STUDENT	LIVES WITH? ☐ Yes ☐ No
WORK ADDRESS -- NUMBER	**STREET**	**CITY**	**ZIP CODE**

CONTACT NUMBERS		Indicate which phone to call for each message type:*				EMAIL ADDRESS:
HOME		EMERGENCY	☐ Home	☐ Cell	☐ Work	
CELL		ATTENDANCE	☐ Home	☐ Cell	☐ Work	
WORK		GENERAL INFO	☐ Home	☐ Cell	☐ Work	
TEXT		☐ I authorize receiving text messages and understand that I am responsible for all text related charges.				

To the principal: In case you are unable to reach me during any emergency, you are authorized to contact and, if necessary, release my child to any of the following:

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE
NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE
NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE

List any other family members attending this school:

LAST NAME	FIRST NAME	HOME ROOM	GRADE	RELATIONSHIP
LAST NAME	FIRST NAME	HOME ROOM	GRADE	RELATIONSHIP

MILITARY CONNECTED FAMILY: In efforts to provide resources and support to military connected students and their families, please respond to the following:	Immediate family member in the military (Active Duty, Guard, Reserve, or Veteran): ☐YES ☐NO Relationship to Student: _____	Currently Deployed: ☐YES ☐NO Military Branch: _____ Status: ☐Active Duty; ☐Guard; ☐Reserve; ☐Veteran; ☐Deceased

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

The undersigned, as parent/legal guardian of, _____ a minor,
(Print name of the student here)

hereby authorizes the principal or designee, into whose care the student has been entrusted, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to the student 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 Los Angeles Unified School District ("District") 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 in accordance with Section 49407 of the California Education Code, and shall remain effective until revoked in writing and delivered to the District. I understand that the District, its officers and its employees assume no liability of any nature in relation to the transportation of the student. 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 my sole responsibility as the student's parent/guardian.

HEALTH ALERTS -- ***List any medical condition which restricts physical activity or requires special attention. Include conditions such as asthma and allergies such as peanut and bee stings. If none, please indicate "none".***

DOES THE STUDENT HAVE HEALTH INSURANCE? (Check One) ☐ YES ☐ NO* **If "Yes":** ☐ Private Health Insurance ☐ Medi-Cal ☐ Healthy Families

MEDI-CAL / HEALTHY FAMILIES ID Number:

1. PRIVATE HEALTH INSURANCE NAME	GROUP NO.	2. PRIVATE HEALTH INSURANCE NAME (If covered under more than one plan)	GROUP NO.
NAME OF DOCTOR / MEDICAL OFFICE		**PHONE NUMBER OF DOCTOR / MEDICAL OFFICE**	

*If the student currently does not have health insurance, information on free or low-cost health care programs is available by calling the District's toll-free HELPLINE 1(866)742-2273.

MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICATIONS:	
MY CHILD CURRENTLY TAKES THE FOLLOWING MEDICATIONS:	

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THIS FORM AND DO HEREBY GIVE MY AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT, AND THAT ALL OF THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE AND CORRECT.

X _____ **DATE**

SIGNATURE OF: (CHECK ONE) ☐ PARENT ☐ LEGAL GUARDIAN CAREGIVER (AFFIDAVIT)

* Selected telephone number must be a direct dial number (no extensions).

Revised January 2014

STUDENT'S LAST NAME

FIRST NAME

MIDDLE INITIAL