CASTRO VALLEY UNIFIED SCHOOL DISTRICT

4400 Alma Avenue, Castro Valley, CA 94546 (510) 537-3000

STUDENT EMERGENCY INFORMATION FORM

STUDENT INFORMATION

Student's Legal Last Name	First Name	MI	Grade	Date of Birth

Address	Phone	School

MEDICAL INFORMATION – Medical Conditions (check all that apply)

☐ ADHD	☐ Cancer	☐ Epi-pen	☐ Kidney/Bladder	☐ Seizure Disorder
☐ Allergies (list below)	☐ Cystic Fibrosis	☐ Hearing Aide/Tubes	☐ Menstrual Problem	☐ Skin Problem
☐ Asthma	☐ Diabetes	☐ Hearing Problem	☐ Migraine Headaches	☐ Stomach Problem
☐ Asthma Inhaler	☐ Ear Infections	☐ Heart Problem	☐ Muscular Dystrophy	☐ Thyroid Condition
☐ Blood Disorder	☐ Eating Disorder	☐ Hernia	☐ Musculo-Skeletal	☐ Tourette syndrome
☐ Bee Sting allergy	☐ Emotional Disorder	☐ Hypoglycemia	☐ Prosthetic Device	☐ Vision/Glasses
☐ Food Restrictions (medical/non medical)			☐ Other	

MEDICATION(S)

If your child receives daily medication, **AT HOME OR AT SCHOOL,** please list the name of the medication, dose, and time it is given. **Medication can only be dispensed at school with a formal request signed by a doctor and parent**. Medication forms are available in the school office or can be downloaded at our district website www.cv.k12.ca.us. **INFORMATION REQUIRED IN CASE OF EMERGENCY.**

Name of Medication:	Dosage (how much):	Times Given:

MEDICAL AUTHORIZATION

As legal guardian of _____, a minor, I hereby authorize the principal or his/her designee, into whose care the aforementioned minor pupil has been entrusted, to consent to an 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.

I understand 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 such diagnosis, treatment, or hospital care which a licensed physician or Dentist may deem necessary. This authorization shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand that the Castro Valley Unified School District, its employees, and its Board assume no liability of any nature in relation to the transportation or treatment of 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 my responsibility.

Preferred Doctor:	Phone No:	Preferred Hospital:

Medical Insurance:	Membership I.D.#:

☐ In the event of an accident or emergency, I give permission for school staff or emergency contact to obtain necessary medical care for my child.

The governing board of a school district requires the parent or legal guardian of a pupil to keep current at the pupil's school of attendance, emergency information including the home address and telephone number, business address and telephone number of the parents or guardian, and the name, address, and telephone of a relative or friend who is authorized to care for the pupil in any emergency situation if the parent or legal guardian cannot be reached. CVUSD BP/AR 5113 allows students to be absent for medical reasons for up to 10 days per year. If a student has had 10 absences for illness in the school year as reported by a parent, any further absences for illness must be verified by a physician.

California Ed Code makes it mandatory that every student be provided with physical education. If, at any time, your child has a condition which requires being excused from activity for more than three (3) school days, an explanatory note is required from your child's doctor.

Medical/Health Information:

Parent/Guardian Signature **Parent/Guardian Signature**

Falsification of Registration Information jeopardizes enrollment in the CASTRO VALLEY UNIFIED SCHOOL DISTRICT

Parent/Guardian Printed Name	Parent/Guardian Signature	Date