SUSD Health Services
Emergency & Health Information

Teacher:	Date Rev.	IHCP Yes ☐ No ☐
Student ID:	Grade	

In case of emergency, illness or accident to: **Student's Name** ______________________

the school is authorized to proceed as indicated below: **DOB (mm/dd/yyyy)** ______________________

ADDRESS: ______________________ City: ______________________ Zip: ______________________

CALL FIRST

Home Phone (_____)_____-________

PRIMARY GUARDIAN: ______________________ (_____)_____-________ (_____)_____-________

Name | Relationship | Work Phone | Cell Phone

Home Phone (_____)_____-________

CALL SECOND: ______________________ (_____)_____-________ (_____)_____-________

Name | Relationship | Work Phone | Cell Phone

Home Phone (_____)_____-________

CALL THIRD: ______________________ (_____)_____-________ (_____)_____-________

Name | Relationship | Work Phone | Cell Phone

Home Phone (_____)_____-________

CALL FOURTH: ______________________ (_____)_____-________ (_____)_____-________

Name | Relationship | Work Phone | Cell Phone

PHYSICIAN: ______________________

Name | Address | Phone Number

If it is not possible to contact any of the above listed persons, I hereby authorize transportation to the nearest medical facility for such emergency medical treatment as deemed necessary for the safety and protection of my child, but not at the expense of the school.

THIS INFORMATION MUST BE COMPLETED YEARLY SO THAT THE SCHOOL CAN ACT ON YOUR BEHALF IN THE EVENT OF A MEDICAL EMERGENCY

I understand that the school district does not provide medical insurance for student Injuries but does make voluntary student insurance available. I have received the information on this program. ☐ Yes ☐ No

PLEASE CHECK ONLY THOSE THAT APPLY: ***SUSD Health Services may be contacting you for a follow up.***

☐ ADHD/ADD: Requires medication? Yes ☐ No ☐ Given at School? Yes ☐ No ☐

☐ Asthma: Requires medication/inhaler? Yes ☐ No ☐ Given at School? Yes ☐ No ☐

☐ Severe Allergies: Severely allergic to:______________________________ Requires Epi-Pen? Yes ☐ No ☐

Symptoms that occur:______________________________

☐ Diabetes: Type I ☐ Type II ☐ Medications: Oral ☐ Injection ☐ Pump ☐ Given at School? Yes ☐ No ☐

☐ Heart Problems: Diagnosis:____________________ Requires medication? Yes ☐ No ☐ Given at School? Yes ☐ No ☐

Physical Restrictions?____

☐ Orthopedic: Orthopedic Condition:________________________ Physical Limitations?________________________

☐ Seizure Disorder: Date of last seizure:________________ Requires medication? Yes ☐ No ☐ Given at School? Yes ☐ No ☐

☐ Vision: Wears Glasses? Yes ☐ No ☐

Please list any other important health or behavioral information that may affect your child while at school that we should be aware of:

____

Calif. Ed. Code 49423- Students taking medication at school need an "**Authorization for Medication**" form completed annually. This form must be on file with the school before medication can be given.

☐ **Student Has no Health Insurance or Medi-Cal**

☐ Health Insurance / Medi-Cal: ________________________ Policy #________________ ID#________________

Under the Local Education Agency (LEA) Billing Options Program for covered health related services in a child's IEP/504/Health Care Plan, your student's public insurance program may be accessed and provided to the school district's LEA Billing Agency. These services may or may not be related to your child's IEP/504/Health Care Plan services and will not impact your child's Medi-Cal coverage. Health related services will be covered at no cost to the parent. Parents or Guardians may withdraw consent for the LEA Billing Options Program at any time by notifying Health Service Department in writing at 975 North D Street, Stockton Ca. 95206

Signature of Parent/Guardian: ____ Date:____________________