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 (dd/mm/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

PLEASE TURN OVER AND FILL OUT BACK OF THIS FORM

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:______________

STOCKTON UNIFIED SCHOOL DISTRICT

STUDENT REGISTRATION FORM

All information will be kept confidential

Grade

STUDENT LAST NAME:

FIRST NAME:

PERMANENT ID:

STUDENT INFORMATION (PLEASE PRINT)

Has your student ever attended Stockton Unified public schools before? ☐ Yes ☐ No

Legal Name: ____
LAST NAME FIRST NAME MIDDLE INITIAL OTHER LEGAL NAME (IF APPLICABLE)

Gender: ☐ Male ☐ Female ☐ Non-Binary

Date of Birth: Month:__________ Day:__________ Year:__________

Home Address: ____
HOME ADDRESS APT#

____
CITY STATE ZIP

Primary Phone: (________) ________-________ E-Mail: ______________________

Brothers and sisters under the age of 18 living at home:

NAME ______ BIRTH DATE __/__/____ (MM/DD/YYYY) NAME ______ BIRTH DATE __/__/____ (MM/DD/YYYY)

NAME ______ BIRTH DATE __/__/____ (MM/DD/YYYY) NAME ______ BIRTH DATE __/__/____ (MM/DD/YYYY)

Residence – where is your child/family currently living? (McKinley-Vento Act Compliance) – Please check appropriate box:

☐ In a single family permanent residence (house, apartment, condo, mobile home)
☐ In a motel/hotel (09)
☐ In a shelter or transitional housing program (10)
☐ Doubled-up (sharing housing with other families / individuals due to economic hardship or loss) (11)
☐ Unsheltered (car/campsite) (12)
☐ Other (15) (please specify) ______________

Ethnicity: Is your child Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)

☐ Yes ☐ No If No, you must complete the next section on below.

What Is Your Child's Race? (Select one or more) The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your child's race to be.

☐ African American or Black
☐ American Indian or Alaskan Native Tribe: ______________
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino/Filipino American
☐ Guamanian
☐ Hawaiian
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Tahitian
☐ Vietnamese
☐ White

PLEASE FILL OUT REVERSE SIDE

PARENT/GUARDIAN INFORMATION

Parent / Guardian I - Legal Name

FIRST NAME ____ LAST NAME ____

☐ FATHER ☐ MOTHER ☐ STEP-FATHER ☐ STEP-MOTHER
☐ GUARDIAN ☐ FOSTER/GROUP HOME ☐ OTHER ____

Cell Phone: (____) ____ - ____

Work Phone: (____) ____ - ____

E-mail: ____

Employer: ____

Work Address: ____

Are you on Active Duty in one of the following Armed Forces branches: Army, Navy, Air Force, Marine Corps, and Coast Guard. ☐ Yes ☐ No
Enlistment Date: ____

Highest Education Level (check one):

☐ NOT A HIGH SCHOOL GRADUATE ☐ HIGH SCHOOL GRADUATE
☐ SOME COLLEGE OR ASSOCIATE'S DEGREE ☐ COLLEGE GRADUATE
☐ POST GRADUATE DEGREE OR HIGHER

Student's Legal Custodian:

Are you the legal guardian of the student? ☐ Yes ☐ No

Do you have educational rights? ☐ Yes ☐ No

Parent / Guardian II - Legal Name

FIRST NAME ____ LAST NAME ____

☐ FATHER ☐ MOTHER ☐ STEP-FATHER ☐ STEP-MOTHER
☐ GUARDIAN ☐ FOSTER/GROUP HOME ☐ OTHER ____

Cell Phone: (____) ____ - ____

Work Phone: (____) ____ - ____

E-mail: ____

Employer: ____

Work Address: ____

Are you on Active Duty in one of the following Armed Forces branches: Army, Navy, Air Force, Marine Corps, and Coast Guard. ☐ Yes ☐ No
Enlistment Date: ____

Highest Education Level (check one):

☐ NOT A HIGH SCHOOL GRADUATE ☐ HIGH SCHOOL GRADUATE
☐ SOME COLLEGE OR ASSOCIATE'S DEGREE ☐ COLLEGE GRADUATE
☐ POST GRADUATE DEGREE OR HIGHER

Student's Legal Custodian:

Are you the legal guardian of the student? ☐ Yes ☐ No

Do you have educational rights? ☐ Yes ☐ No

☐ **Custody: Is there a legal custody agreement regarding this student?** If so, please provide legal documentation

☐ **Duplicate Mailing**: If divorced/separated & joint custody allows duplicate mailing/information to be given to another parent. Please include their name, address, & phone number:
Full Name: ____ Phone: (____) ____ - ____
Mailing Address: ____ City/State/Zip ____

STUDENT INFORMATION CONTINUED

Most Recent Schools Attended:

SCHOOL ____ ADDRESS/CITY/STATE/ZIP ____ GRADE(S) ____ DATE(S) ____

SCHOOL ____ ADDRESS/CITY/STATE/ZIP ____ GRADE(S) ____ DATE(S) ____

Has your child ever been retained? ☐ Yes ☐ No Grade Level(s) ____

Are there psychological or confidential reports available from your child's former school? ☐ Yes ☐ No

Has your child been suspended? ☐ Yes ☐ No Has your child **EVER** been expelled? ☐ Yes ☐ No SARB? ☐ Yes ☐ No

What special services has your child received? (***please check all boxes that apply***)

SPECIAL EDUCATION: ☐ IEP ☐ Resource (RSP) ☐ Special Day Class (SDC) ☐ Speech/Language

OTHER: ☐ Gifted (GATE) ☐ Remedial Math ☐ Remedial Reading ☐ Counseling ☐ English Language Development ☐ 504
☐ Other (Specify) ____

I give authorization to this school to request:

☑ Cumulative records ☑ Transcripts (High School ONLY) from any and all schools previously attended.

☐ As the parent/legal guardian of this student, I authorize the school to furnish and exchange oral and written information with the Human Services Agency regarding student name, DOB, address, enrollment, and attendance and graduation status. I understand that my authorization is voluntary and not required for school registration and that this request may not apply to my child's particular circumstances. (signature box)

My signature certifies that all information provided on this form is accurate. I understand that changes in address, telephone numbers and/or emergency information must be reported to the school within 24 hours for the safety of my child.

SIGNATURE OF PARENT/GUARDIAN ____ DATE ____

Young Adult Program

- Documents needed for Registration

- Birth Certificate
- Photo ID
- Proof of Address
- Immunizations
- Current IEP
- Student Registration Card
- Student Emergency Card