

Entered into Aeries

Date: _____ By: _____

**EMERGENCY CARD FORM
Union Mine High School**

Student Name: _____
(Last Name) (First Name) (Middle Name)

Date of Birth: _____ Gender: M F Grade: _____

Students Cell: () _____ Student's Email: _____

Student's Address: _____
(Mailing Address) (City) (Zip)

(Physical Address) (City) (Zip)

<input type="checkbox"/> Father	<input type="checkbox"/> Stepfather	Living with Student	<input type="checkbox"/> Mother	<input type="checkbox"/> Stepmother	Living with Student
<input type="checkbox"/> Guardian	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Guardian	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Parent/Guardian Name: _____			Parent/Guardian Name: _____		
Address, If not living with student		Receive Copy of Mail <input type="checkbox"/> yes <input type="checkbox"/> no	Address, If not living with Student		Receive Copy of Mail <input type="checkbox"/> yes <input type="checkbox"/> no
_____ Street Address, City, Zip Code			_____ Street Address, City, Zip Code		
Primary Phone: _____		Cell Phone: _____	Primary Phone: _____		Cell Phone: _____
Parent's E-Mail: _____			Parent's E-Mail: _____		
Employer: _____		Work Phone: _____	Employer: _____		Work Phone: _____

In case the student's parent/guardian cannot be reached, the school will contact and/or release the student to the following adults:

Adults Name	Day-Time Phone	Cell Phone	Relationship to Student

PLEASE COMPLETE REVERSE SIDE OF EMERGENCY CARD

Siblings: _____
Names/Ages/Schools

Names/Ages/Schools

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Names/Ages/Schools

Names/Ages/Schools

Check any of the following programs in which the student has currently enrolled:

Special Education

GATE (gifted)

Section 504 Accommodations

Bilingual

Family Physician: _____
(Name) (Phone)

Allergic Reactions: YES NO If yes, type of allergy: _____

Asthma: YES NO If yes, medication taken if any: _____

Seizure Disorder: YES NO If yes, type: _____

Diabetes: YES NO Tetanus-Date of last immunization: _____

Medication Taken: YES NO If yes, name: _____

Annual Notification to Parents/Guardians Allow Deny

Technology Acceptable Use Policy Allow Deny

Student Internet Use Authorization Allow Deny

Military Release Information Allow Deny

Release of Student Images or Work
(including photo in Yearbook) Allow Deny

NOTE: If your child needs to take medication during school hours, a form must be signed by the Parent/Guardian AND Physician before the school can administer medications.

Other Medical Conditions: _____

Health Insurance Carrier: _____ Policy Number: _____

I/We authorize the District's Authorized personnel to administer first aid and to obtain medical care for my/our child, _____ in the event of an accident, injury, or illness.

I/We the parents of _____ a minor, authorize the El Dorado Union High School District to act as my/our agent in my/our absence to obtain through the physician named above such medical or hospital care as is reasonably necessary for the welfare of the student, including necessary transportation. In the event said physician is not available at the time, I /we authorize such care and treatment to be performed by any licensed physician or surgeon. I/We agree to bear all costs incurred as a result of the foregoing.

Father/Guardian Signature

Date

Mother/Guardian Signature

Date