SANTA CLARA UNIFIED SCHOOL DISTRICT

EMERGENCY RELEASE FORM

School Year: 20 _____ - 20 _____

STAFF USE ONLY
☐ Court Order
☐ Medical Alert

Please print or type all information.

Last name _____ First name _____

Address _____

City/State/Zip _____

Phone _____ Student ID# :_____ Grade _____

Birthdate _____ Sex: M/F _____ Language spoken at home _____

Student lives with both parents? YES or NO If no, which parent does student live with?_____

Parent/Guardian (Father) _____

Where employed _____ Phone _____

Cell phone:_____ Other _____

Parent/Guardian (Mother) _____

Where employed _____ Phone _____

Cell phone:_____ Other _____

Siblings in SCUSD:

Name _____ School_____ Grade _____

Name _____ School_____ Grade _____

Name _____ School_____ Grade _____

In the event of an emergency or disaster, your student will only be released to the persons authorized on this form if we are unable to reach you. Individuals must be 18 years or older. Due to anticipated road damage after a major disaster, it may take additional hours to reach the school. For this reason, choose individuals who live within walking distance. Be sure these persons know (1) that they are authorized to pick up your student, and (2) at what point you would expect them to pick up – immediately or only upon hearing from you.

I authorize the following individuals to pick up my student in case of emergency or disaster:

NAME/RELATIONSHIP	DAYTIME ADDRESS	DAY PHONE # (INCLUDE AREA CODE)	CELL/PAGER # (INCLUDE AREA CODE)

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FOR STAFF USE ONLY

Released to _____ ID shown _____

Destination _____

Has this person been in contact with parent since disaster? Y/N _____

Date/Time _____ Released by _____

Revised 06/2013
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If telephone service is interrupted, long distance will be the first service restored. Please list an out-of-town contact your family will use.

Name/Relationship _____ Phone _____

Address _____ City/State/Zip _____

Doctor _____ Phone _____

Dentist _____ Phone _____

Student's health insurance _____ Medical record number _____

The school seeks advice and cooperation of parents and physicians in maintaining the health of pupils. In order that we may know more about your student's health, please complete the information below.

Please list your student's health problems, if any, and explain. (Examples: diabetes, asthma, severe allergies, heart problems, seizures, bone/joint problems, or other health concern.)

_____

_____

Vision difficulties: Y/N_____ Eye glasses: Y/N_____ Hearing difficulties: Y/N_____

Medication at school: Any student who must take medication (prescription or over-the-counter) during school hours may be assisted by school staff provided there is a detailed written prescription from a licensed health care provider, written parental request, and the medication is supplied in the original container. Medication Authorization Forms are available in the school office.

Please list the medications your student is taking on a continuing basis:

Medication/dosage _____

Reason for medication _____

Name of physician supervising treatment _____

Medication in the nurse's office: Y/N_____

Emergency treatment: If school authorities deem it necessary, your child will be taken by ambulance at the parent's expense to the nearest emergency facility where the attending physicians (or dentist) on duty may perform emergency treatment on your child.

I acknowledge that I have read the Emergency Release Form and that I am aware of District procedures in the event my child is seriously injured or there is a catastrophic event. I certify that the information I have provided is accurate and current. Should a change in the information I have provided occur, I will immediately inform the school office of the change and update this form to ensure that my emergency contacts are available as needed.

Signature (Parent/Guardian) _____ **Date** _____