

PLEASE PRINT /Complete and sign form. Incomplete information on this card will result in a DELAY for your child to receive his/her class schedule. It is the parent/guardian's responsibility to notify the school of any changes of address or telephone number, either at home or work. If your child becomes ill or is injured at school, it is important that information on this card is accurate and complete. One card will be on file in the Nurse's Office, one in your child's House Office, and one in the Emergency Bin.

Permit: Yes No

Grade: _____ House: _____

Samohi Student Emergency Information and Authorization

Student's Last Name	First Name	MI	HOME Phone (Primary)	DAY Phone (Alternate)
Student's Address	City	State	Zip	Student ID Number
Student's Email Address			Student's Cell Phone	Student's Birthday
Parent 1's (Guardian 1's) Name	Occupation	Parent 1's CELL Phone		Parent 1's WORK Phone
Parent 1's Employer and Employer Address			Parent 1's Email Address	
Parent 2's (Guardian 2's) Name	Occupation	Parent 2's CELL Phone		Parent 2's WORK Phone
Parent 2's Employer and Employer Address			Parent 2's Email Address	

Custody: Child lives with: Both Parents Parent 1 Parent 2 Guardian Other: _____

Joint Custody, Arrangements (Days): _____

When BOTH parents/guardians plan a temporary absence from the home: NOTIFY THE OFFICE IN WRITING of the name(s) and phone numbers of adult(s) who will be responsible in the event of an emergency.

EMERGENCY RELEASE: If parents cannot be reached, the school is ONLY authorized to release your child to these LOCAL PERSONS

	Name	Relationship	Address	Phone (Day or Cell)
1.				
2.				
3.				

IN THE EVENT OF A MEDICAL EMERGENCY, if I cannot be reached, I hereby give consent for my child to be transported to an Emergency facility and to receive attention from a physician or dentist.

Name of Health Insurance/MediCare	Subscriber Number	Group Number	Phone Number
Physician/Doctor's Name	Address	Phone Number	Date of Last Exam
Dentist Name	Address	Phone Number	Date of Last Exam

Identify any Health Problems:

Allergic to: _____

Current Medications taken at home or school: _____

AUTHORIZATION FOR MEDICATION, will not be given without your signature. If left blank or crossed out, medication will NOT be made available to your child. I hereby request that the school nurse make available the following medication(s) to my child as prescribed by the District physician consultant:

Medication (cross out if do NOT want given)	Dosage (same for either medication)	Route/Frequency	Parent SIGNATURE Required
Acetaminofen (Tylenol) - 325mg/tablet	1 tablet (if student weighs less than 100 pounds)	By mouth Every 4-8 Hours	
Ibuprofen (Motrin, Advil) - 200mg/tablet	2 tablets (if student weighs 100 pounds or more)		

PLEASE INITIAL BELOW

I authorize the release of photos and videos of my child for school related media during the school year. Yes _____ No _____

I give consent for our names, addresses, telephone numbers and/or email addresses to be included on a class roster, distributed to the PTSA, and to other families in my child's class. Yes _____ No _____

Parent or Legal Guardian Signature

Date