

Galt Joint Union Elementary School District

Student Emergency Information

1018 C Street, Suite 210, Galt, CA 95632-1733 (209)744-4545 (209)744-4553 Fax www.galt.k12.ca.us

Do not complete this form if your child was registered within the last 60 days

This Form is Available On-Line at www.galt.k12.ca.us

Student Information

Student's Legal Name (Last) _____ (First) _____ (MI) _____ (AKA) _____

Residence Address _____ City _____ Zip Code _____

Home Phone (_____) _____

Mailing Address (if different) _____ City _____ Zip Code _____

Gender M F Birth Date _____ How does your child get to and from school? _____

Teacher _____ Room # _____ Grade _____

Parent Information (those living with student)

Check One Mother Stepmother Guardian Foster Other _____

Mrs. Ms. Miss Dr. Other _____

Last Name _____ First Name _____

Employment By _____ City _____ Work Phone & Ext. (_____) _____ DNC

Cell/Message Phone (_____) _____ Work email _____ Home email _____

Check One Father Stepfather Guardian Foster Other _____

Mr. Dr. Other _____

Last Name _____ First Name _____

Employment By _____ City _____ Work Phone & Ext. (_____) _____ DNC

Cell/Message Phone (_____) _____ Work email _____ Home email _____

Please indicate the highest level of education in the household - Check One

- Not a high school graduate (includes GED)
 High School Graduate
 Some college (includes AA and vocational school)
 College graduate (four year degree)
 Graduate school (MA, PhD, etc.)
 Declines to state

Other Children Living in the Home

Name (Last, First)	Grade	Teacher	Relationship to Student
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Family Information

Is there a birth parent not living in the home? If yes, please complete below. Deceased Parent? Yes No

Last Name _____ First Name _____ Home Telephone (_____) _____

Address _____ City _____ State _____ Zip Code _____

-Is there a court order regarding custody of this child? Yes No Is there a restraining order regarding a birth parent or other party? Yes No

-If yes to either question, you must provide the school with a copy of the most current court order within 10 days of registering your child.

-If no court order is provided, information will be released to this parent upon request. Court orders must be renewed annually.

(initials required)

Residence

Where is this child currently living? (This question is federally mandated by NCLB)

- Single family permanent residence (House, apartment, condo, mobile home) 200
 Doubled-up (sharing housing with other families or individuals due to economic hardship or loss) 120
 In a shelter or transitional housing program 100
 In a motel or hotel 110
 Unsheltered (car/campsite) 130
 Foster Family Home or Kinship Placement 210
 Other (please specify) 300 _____

Emergency Contact Information (other than parent)

List names of all people authorized to pick up child other than parent (*step parent, grandparent, friends, etc.*). Must be 18 years of age or older.

Relationship	Name	Home Phone	Contact Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical Information

Medical Conditions (Check all that apply)

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Emotional Disorder | <input type="checkbox"/> Kidney/Bladder | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Allergies (<i>severe</i>) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Aide/Tubes | <input type="checkbox"/> Menstrual Problem | <input type="checkbox"/> Skin Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stomach Problem |
| <input type="checkbox"/> Asthma Inhaler | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Bee Sting | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hernia | <input type="checkbox"/> Musculo-Skeletal | <input type="checkbox"/> Tourette Syndrome |
| <input type="checkbox"/> Bee Sting Kit | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Prosthetic Device | <input type="checkbox"/> Vision/Glasses |
| <input type="checkbox"/> Other _____ | | | | |

Medication(s)

If your child receives daily medication, please list the name of the medication, dose, and time it is given. Medication cannot be dispensed at the school without a formal request signed by a doctor and parent. Medication forms are available in the school office.

Name	Dosage (<i>How Much?</i>)	Times Given
_____	_____	_____
_____	_____	_____
_____	_____	_____

As legal custodian of _____, minor, I hereby authorize the principal or his/her designee, into whose care the aforementioned minor pupil has been entrusted, to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to said minor upon the advice of any licensed physician and/or dentist.

I understand that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary.

This authorization shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand that the Galt Joint Union Elementary School District, its employees, and its Board assume no liability of any nature in relation to the transportation or treatment of said minor.

I further understand that all costs of paramedic transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my responsibility.

Preferred Doctor _____ Phone No. (_____) _____ Preferred Hospital _____

Health Insurance Carrier _____ Group No. _____ Policy No. _____

- In the event of an accident or emergency, I give permission for school staff or emergency contact to obtain necessary emergency medical care for my child.
- I do not consent to medical care for my child (*I release the school/district from liability*). Please initial. _____

Parent/Guardian Signature _____

Every adult wishing to participate in a school or classroom activity or chaperone a field trip must be cleared through the **Megan's Law Database**. Volunteer Forms are available on line at www.galt.k12.ca.us or from your child's school office.

PLEASE RETURN THIS EMERGENCY FORM TO YOUR CHILD'S TEACHER.

Parent/Guardian Signature _____ **Print Name** _____ **Date** _____