



**LOS ANGELES UNIFIED SCHOOL DISTRICT  
STUDENT EMERGENCY INFORMATION FORM**

Attachment A

**Parent Information: Please fill out completely and sign where indicated. In a major emergency, it is school district policy to retain students at school for their safety. This form will be used by the school staff when students are released to go home. Please complete electronically or print clearly and return completed form to school.**

STUDENT'S LAST NAME				FIRST NAME				M.I.		STUDENT'S LAST NAME	
BIRTH DATE		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		GRADE		HOME LANGUAGE					
STUDENT'S HOME ADDRESS -- NUMBER			STREET			APT #		CITY			ZIP CODE
MAILING ADDRESS -- NUMBER <small>(IF DIFFERENT FROM ABOVE)</small>			STREET			APT #		CITY			ZIP CODE
PARENT'S / LEGAL GUARDIAN'S LAST NAME			FIRST NAME			RELATIONSHIP TO STUDENT			LIVES WITH? <input type="checkbox"/> Yes <input type="checkbox"/> No		
WORK ADDRESS -- NUMBER		STREET				CITY			ZIP CODE		
CONTACT NUMBERS			Indicate which phone to call for each message type:*				EMAIL ADDRESS:				
HOME		EMERGENCY	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work						
CELL		ATTENDANCE	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work						
WORK		GENERAL INFO	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work						
TEXT		<input type="checkbox"/>	I authorize receiving text messages and understand that I am responsible for all text related charges.								
PARENT'S / LEGAL GUARDIAN'S LAST NAME			FIRST NAME			RELATIONSHIP TO STUDENT			LIVES WITH? <input type="checkbox"/> Yes <input type="checkbox"/> No		
WORK ADDRESS -- NUMBER		STREET				CITY			ZIP CODE		
CONTACT NUMBERS			Indicate which phone to call for each message type:*				EMAIL ADDRESS:				
HOME		EMERGENCY	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work						
CELL		ATTENDANCE	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work						
WORK		GENERAL INFO	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work						
TEXT		<input type="checkbox"/>	I authorize receiving text messages and understand that I am responsible for all text related charges.								
<p><i>To the principal: In case you are unable to reach me during any emergency, you are authorized to contact and, if necessary, release my child to any of the following:</i></p>										FIRST NAME	
NAME			RELATIONSHIP		HOME PHONE		CELL PHONE		WORK PHONE		
NAME			RELATIONSHIP		HOME PHONE		CELL PHONE		WORK PHONE		
NAME			RELATIONSHIP		HOME PHONE		CELL PHONE		WORK PHONE		
<p><i>List any other family members attending this school:</i></p>											
LAST NAME			FIRST NAME			HOME ROOM	GRADE	RELATIONSHIP			
LAST NAME			FIRST NAME			HOME ROOM	GRADE	RELATIONSHIP			
<p><b>MILITARY CONNECTED FAMILY:</b> In efforts to provide resources and support to military connected students and their families, please respond to the following:</p>			Immediate family member in the military (Active Duty, Guard, Reserve, or Veteran): <input type="checkbox"/> YES <input type="checkbox"/> NO Relationship to Student: _____			Currently Deployed: <input type="checkbox"/> YES <input type="checkbox"/> NO Military Branch: _____ Status: <input type="checkbox"/> Active Duty; <input type="checkbox"/> Guard; <input type="checkbox"/> Reserve; <input type="checkbox"/> Veteran; <input type="checkbox"/> Deceased					
<p><b>AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT</b></p>											
The undersigned, as parent/legal guardian of, _____ a minor, <p align="center"><small>(Print name of the student here)</small></p> hereby authorizes the principal or designee, into whose care the student has been entrusted, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to the student upon the advice of any licensed physician and/or dentist. It is understood that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the Los Angeles Unified School District ("District") to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary. This authorization is given in accordance with Section 49407 of the California Education Code, and shall remain effective until revoked in writing and delivered to the District. I understand that the District, its officers and its employees assume no liability of any nature in relation to the transportation of the student. 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 sole responsibility as the student's parent/guardian.											
<p><b>HEALTH ALERTS -- List any medical condition which restricts physical activity or requires special attention. Include conditions such as asthma and allergies such as peanut and bee stings. If none, please indicate "none".</b></p>											
<p><b>DOES THE STUDENT HAVE HEALTH INSURANCE? (Check One) <input type="checkbox"/> YES <input type="checkbox"/> NO*</b> If "Yes": <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Healthy Families</p>											
MEDI-CAL / HEALTHY FAMILIES ID Number:											
1. PRIVATE HEALTH INSURANCE NAME			GROUP NO.		2. PRIVATE HEALTH INSURANCE NAME <small>(If covered under more than one plan)</small>			GROUP NO.			
NAME OF DOCTOR / MEDICAL OFFICE					PHONE NUMBER OF DOCTOR / MEDICAL OFFICE						
<p>*If the student currently does not have health insurance, information on free or low-cost health care programs is available by calling the District's toll-free HELPLINE 1(866)742-2273.</p>											
MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICATIONS:											
MY CHILD CURRENTLY TAKES THE FOLLOWING MEDICATIONS:											
<p><b>I CERTIFY THAT I HAVE READ AND UNDERSTOOD THIS FORM AND DO HEREBY GIVE MY AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT, AND THAT ALL OF THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE AND CORRECT.</b></p>											
X			DATE								
SIGNATURE OF:			<input type="checkbox"/> (CHECK ONE) PARENT	<input type="checkbox"/> LEGAL GUARDIAN	CAREGIVER (AFFIDAVIT)						