

## LOS ANGELES UNIFIED SCHOOL DISTRICT STUDENT EMERGENCY INFORMATION FORM

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.	] <u>s</u>	
BIRTH DATE		GRADE HOME LANGUAGE										STUDENT'S LAST NAME			
	FEMALE												S.L		
STUDENT'S HOME ADDRESS NUMBER STREET								AI	APT# CI		CITY			ZIP CODE	J.S.T
MAILING ADDRESS NUMBER (IF DIFFERENT FROM ABOVE)								Al	°T #		CITY			ZIP CODE	NAME
PARENT'S / LEGAL GUARDIAN'S L/	ST NAME					RE	RELATIONSHIP TO STUDENT					LIVES WITH?			
WORK ADDRESS NUMBER ST						Ci	CITY					ZIP CODE	1		
CONTACT NUMBERS			Indicate which phone to call for each message					ne tvo	e type:*   EMAIL ADDRESS:					A A A A A A A A A A A A A A A A A A A	┨
HOME									Vork						
CELL				ATTENDANCE  Home  Cell					Work						
WORK			GENERAL INFO [ Home Cell					ľ	Work						
PARENT'S / LEGAL GUARDIAN'S LAST NAME FIRS			ST NAME					RE	RELATIONSHIP TO STUDENT					LIVES WITH?	
WORK ADDRESS NUMBER STREET									CITY					ZIP CODE	-
							e type:*   EMAIL ADDRESS:								
CONTACT NUMBERS HOME				Indicate which phone to call for each mess EMERGENCY					Vork	EMA	IL ADDRESS:				
1															
CELL			ATTENDANCE [_] Home				Cell		□ Work						}
WORK			GENERAL INFO  Home  Cell												
To the principal: In case you are un	able to r	each me o	uring any o	omorgency,	you are a	uthor	rized to co HOME P	ntect	and, if n	eçess	ary, release my a	child to a	ny of the	following:	-
NAME			RELATION	RELATIONSHIP			HOWER	HUNE	•		CELL PHONE WO		WORF	ORK PHONE	
NAME			RELATIONSHIP H				HOME PHONE				CELL PHONE WOR		WORK	( PHONE	FIRST NAVE
NAME			RELATIONSHIP HOM				HOME P	HONE CELL PHONE				WORK PHONE			
List any other family members atten	dina this	school:	<u> </u>		,										1
LAST NAME	FIRST NAME						HOME ROOM GRADE RELATIONSHI								
LAST NAME			FIRST N	FIRST NAME					HOME ROOM GRADE			RELATIONSHIP			
	VII	THORE	ZATION	FORE	MERG	ENG	CY ME	DIC	AI TE	ΣΕΔ.	TMENT	.E			1
The undersigned, as perent/legal guard		HOK	CATION	FORE	MENG		01 1412	DIO	~L 11	\I(\	1 1714-14 1			a minor,	
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, o	r hospita	care and	us sebivoro	thority and p	oower to th	e Los	Angeles U	Inified	School (	District	("District") to give	e specific (	consent t	o any and ali	
such disgnosis, treatment, or hospital	care wh	ich a licen	sed physici	an or dentis	st may dec	om no	cossary.	This a	uthorizat	tion is	given in accorda	ance with	Section 4	49407 of the	
California Education Code, and shall re	emain eff traven <i>ort</i> :	ective until	nt beyoked in	writing and	Detection	to the Halle	District. 3	unger amedi	stand the	at the I	District, its onicer: n. hospitalization	s and anv e and anv e	mpioyee: exeminati	s assume no on X-ray or	
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.															
HEALTH ALERTS – List any modical condition which restricts physical activity or regulros special attention. Include conditions such as asthma and allergios such as peanut and bee stings. If none, please indicate "none".															
DOES THE STUDENT HAVE HEALTH INSURANCE? (Check One) YES NO* If "Yes":   Private Health Insuranco Medi-Cal Healthy Families															
MEDI-CAL / HEALTHY FAMILIES ID I	Number:										·			/01-111/9889	1 3
1. PRIVATE HEALTH INSURANCE NAME			GROUP NO.				RIVATE HE				NAME		GROUP NO.		MIDDLE
NAME OF DOCTOR / MEDICAL OFFICE PHONE NUMBER OF DOCTOR / MEDICAL OFFICE															돧
*If the student currently does not have MY CHILD IS ALLERGIC TO THE FO	health ins	orance, in	formation or	free or low	-cost healt	h care	programs	is ava	ilablo by	callin	g the District's toll	-free HELI	PLINE 1(	866)742-2273.	-
MY CHILD IS ALLERGIC TO THE FO								· <b>.</b> .							1
I CERTIFY THAT I HAVE READ AND	UNDER	STOOD TI	IIS FORM	AND DO HE	EREBY GI	VE M	Y AUTHO	RIZATI	ION FOR	R EME	RGENCY MEDIC	AL TREA	TMENT,	AND THAT ALL	1
OF THE INFORMATION I HAVE PRO	VIDED O	N THIS FO	RM IS TRU	IE AND CO	RRECT.										
X CIONATION OF	(CUEA)/	ONEY "	T DADGE	<del></del>	TIECN	COLUMN	HAIRN		w		DATE			10-11	-
X DATE  SIGNATURE OF: (CHECK ONE)   PARENT   LEGAL CUARDIAN  SIGNATURE OF: (CHECK ONE)   PARENT   LEGAL CUARDIAN  Stephen State Stat														1	