COLTON JOINT UNIFIED SCHOOL DISTRICT
STUDENT EMERGENCY INFORMATION FORM

Please fill in the information requested completely and accurately

(OFFICE USE ONLY) DATE:_____ TEACHER:_____ GRADE_____ STUDENT ID#_____

Student's Information

Last Name	First Name	Middle Name

Grade:	Birthdate:	Gender: ☐M ☐F ☐Non-binary	Student Contact #: ☐Student Cell ☐Parent Cell ☐Home Phone ☐Student may receive text message notifications

STUDENT'S HOME ADDRESS:

ADDRESS CITY ZIP CODE

STUDENT'S MAILING ADDRESS (IF DIFFERENT FROM ABOVE)

Parent/Legal Guardian/Caregiver enrolling student with whom the student lives with on a day to day basis:

PARENT/LEGAL GUARDIAN/CAREGIVER LAST NAME	FIRST NAME	RELATIONSHIP TO STUDENT: Live with student ☐
Home Address:	Apt # City:	State: Zip:
EMPLOYER: Address: WORK PH#:	PRIMARY PH#_____ EMAIL ADDRESS:	CELL PH# _____ Receive text messages ☐

PARENT/LEGAL GUARDIAN/CAREGIVER LAST NAME	FIRST NAME	RELATIONSHIP TO STUDENT: Live with student ☐
HOME ADDRESS:	Apt # City:	State: Zip:
EMPLOYER: Address: WORK PH#	PRIMARY PH#_____ EMAIL ADDRESS:	CELL PH# _____ Receive text messages ☐

EMERGENCY CONTACTS

In case the school is **unable to reach** parent/legal guardian/caregiver the following responsible adults may be contacted in case of an emergency or disaster. Person must be 18 years or older with a valid contact number.

Emergency contact #1

First/Last Name: _____ Contact #: _____

Relationship:

Emergency contact #2

First/Last Name: _____ Contact #: _____

Relationship:

Emergency contact #3

First/Last Name: _____ Contact #: _____

Relationship:

Where is your child/family currently living: *(check one box only)*
This information will be used to determine if your child qualifies for additional assistance under the McKinney Vento Act.

☐ In a single family residence (only 1 family living in this residence)
☐ With more than one family in a residence *not* due to economic hardship
☐ With more than one family in a residence due to economic hardship
☐ In a foster care placement/group home
☐ In a hotel/motel
☐ In a shelter or transitional housing
☐ Temporarily unsheltered (car, etc.)
☐ Living with other than parent/legal guardian temporarily–Caregiver Aff.

UNITED STATES ARMED FORCES
Is either parent/guardian on Active Duty in the Armed Forces or National Reserve:
yes ☐ no ☐ If yes, date started:
Is other parent/guardian on Full-time National Guard Duty:
yes ☐ no ☐ If yes, date started:

Names of siblings in District and/or in the Home:

Name: _____ School: _____ dob: _____
Name: _____ School: _____ dob: _____
Name: _____ School: _____ dob: _____
Name: _____ School: _____ dob: _____

Medical History: My child is allergic to the following medications/food/insect bites: ☐ None	My child takes the following medications at school:	My child takes the following medications at home:
Health Plan/Insurance Co. Group Policy #: ☐None	My child has the following health problems:	My child has no medical issues:☐ Parent Initials: _____
Family Doctor:	Daytime Ph#:	Address:

Parent's Rights
I have read the information on this form and understand its content. My signature verifies that I have been informed of my rights as a parent/legal guardian/caregiver of a public school student. My signature DOES NOT indicate consent to participate in a particular program. I will send written notice to the school of any specific objections I have regarding my student's participation in a particular program or service. I understand that the health information may be shared verbally or in writing with school district personnel.

Signature of Parent/Legal Guardian/Caregiver: Date:

☐ I object to the release of student information of my student
☐ I do not object to the release of student information of my student
Parent initials: Date:

As legal custodian of_____, a 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 and provides authority and power to the aforementioned agent(s) 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 shall remain effective unless revoked in writing and delivered to said agent(s). I understand that the Colton Joint Unified 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.

Signature of Parent/LegalGuardian/Caregiver: Date: