EMERGENCY CARD
2019/2020

Folsom Cordova Unified School District
HIGH SCHOOL
STUDENT EMERGENCY INFORMATION

Please circle student's grade for 2019/2020 School Year

09 10 11 12

(Please Print)

Student's Legal Name: _____
(Last) (First) (Middle)

Also Known as (AKA) Name: _____ **Sex:** ☐ Male ☐ Female

Home *(Resident)*Address:_____**City:** _____**State:**_____ **Zip Code:** _____

Mailing Address *(if different):*_____**City:** _____ **State:** _____**Zip Code:** _____

Home Phone: _____ **Date of Birth:** _____
(333-444-5555) *(Month) (Day) (Year)*

Emergency Release information required below

Mother's Name:_____ **Check one***:* ❑*Natural* ❑ *Step* ❑*Guardian/Foster*

Address if different than student: _____

Home Phone:_____ **Cell Phone:** _____

Work Phone/Pager:_____**Email:** _____

Father's Name:_____ **Check one:** ❑*Natural* ❑*Step* ❑*Guardian/Foster*

Address if different than student: _____

Home Phone:_____ **Cell Phone:** _____

Work Phone/Pager:_____**Email:**_____

Guardian's Name:_____ **Check one:** ❑*Guardian/Foster*

Address if different than student: _____

Home Phone:_____ **Cell Phone:** _____

Work Phone/Pager:_____**Email:**_____

Student lives with: _____

If parents are divorced or separated, to whom has physical custody been granted? (Please attach verification)

_____ **Custody papers on file** ❑

DO NOT release to: _____

EMERGENCY RELEASE INFORMATION *(Ref. Ed. Code 49408)*

If my child is ill, has an emergency, or is suspended and I cannot be reached, please call and release my child **in order of preference** to:

Name:_____ Phone(s):_____
Please indicate: ❑ Neighbor ❑ Relative ❑ Friend ❑ Other

Name:_____ Phone(s):_____
Please indicate: ❑ Neighbor ❑ Relative ❑ Friend ❑ Other

Name:_____ Phone(s):_____
Please indicate: ❑ Neighbor ❑ Relative ❑ Friend ❑ Other

Signature below verifies all of the information on this form to be true under penalty of perjury.

_____ _____
Parent/Guardian Signature *Date*

HIGH SCHOOL
2019/2020

Folsom Cordova Unified School District

STUDENT HEALTH INFORMATION CONFIDENTIAL

Please circle student grade for the 2019/2020 school year
09 10 11 12

STUDENT NAME: _____ **DATE OF BIRTH:** _____

Does your student take any medication? ❑ Yes ❑ No During school hours? ❑ Yes ❑ No

Please specify **name of medication** and **dosage:** _____

Prescribed by **Doctor *(list name)*:** _____

A completed Medication Administration Form is required for each medication to be administered at school.

Please check/list all that apply to student:

MEDICAL ALERT

- ❑ No known health problems
- ❑ Asthma
- ❑ Diabetes
- ❑ Hearing problems ❑ Hearing Aid
- ❑ Heart condition
- ❑ Seizure Disorder
- ❑ Vision problems
  _____glasses _____contact lenses
- ❑ Other health conditions, please specify:

_____
_____
_____
_____

ALLERGIES

❑ Bee sting ❑ Yes ❑ No
Severe, requires emergency treatment ❑ Yes ❑ No
Medication required ❑ Yes ❑ No
Epipen/Epinephrine ❑ Yes ❑ No
Benadryl/Antihistamine ❑ Yes ❑ No

❑ Medications your child is allergic to: (*please specify*)
_____

❑ Foods your child is allergic to: (*please specify*) _____

_____ Anaphylaxis ❑ Yes ❑ No

Other Allergies:_____

Describe reaction:_____

Physician's Name: _____ **Phone:** _____

Medical Insurance ❑ Yes ❑ No
Family Health Insurance ❑ Yes ❑ No Provider Name / Number ID _____
Medi-Cal ❑ Yes ❑ No Provider Name / Number ID _____

For the Health and Safety of your child, the medical information you have shared above will be reviewed by the School Nurse and Site Administrator who will only release this information to those on staff with a legitimate need to know. In case of an accident or sudden illness, when a parent or guardian is unavailable, I authorize a school representative to obtain medical care for my child, including necessary transportation, in accordance with their best judgment. I further authorize the doctor named above to provide the care and treatment he or she considers necessary. If the physician designated is unavailable I authorize such care and treatment to be performed by a licensed physician or surgeon selected by the school representative, who will be given the information on this card. I agree to pay all costs incurred as a result of the foregoing.

The District, in cooperation with the California Departments of Health Care Services and Education, participates in a program that allows the district to be reimbursed with federal Medicaid dollars for select health services provided to Medi-Cal eligible students at school. In order for the district to receive reimbursement for these services, we must obtain your consent to release limited education records to the Department of Health Care Services (DHCS) and our reimbursement recovery vendor; and we must obtain your consent to access public benefits if your child is enrolled in Medi-Cal.* Our vendor holds a contract with the district that contains a specific confidentiality clause to ensure information is not disclosed inappropriately; further, our vendor is HIPAA (Federal Health Insurance Portability and Accountability Act) compliant. Records that may be shared include: child's name and date of birth; and health-related evaluation, intervention, and referral information (for services received at school), all of which are shared securely.

_____ I consent to the release of my child's related health records, and to access my child's Medi-Cal benefits (if enrolled)

_____ I do not consent to the release of my child's related health records, and to access my child's Medi-Cal benefits (if enrolled)

*Note - School health services currently provided to all students will not be changed by this program. *Your consent, or non-consent, **does NOT affect** the services available and provided to your child, and should not impact your Medi-Cal benefits.*

_____ _____
Parent/Legal Guardian Signature *Date*

Print Parent/Guardian Name: _____