Entered into Aeries
Date:_____ By: _____

EMERGENCY CARD FORM
Union Mine High School

Student Name: _____
(Last Name) (First Name) (Middle Name)
Date of Birth:_____ Gender: M ☐ F ☐ Grade: _____

Student's Cell: _(____)_____ Student's Email: _____

Place of Birth: _____

Student Address: _____
(Mailing Address) (City) (Zip)
_____
(Physical Address) (City) (Zip)

○ Father ○ Stepfather LIVING WITH STUDENT ○ Guardian ○ YES ○ NO	○ Mother ○ Stepmother LIVING WITH STUDENT ○ Guardian ○ YES ○ NO
Parent/Guardian Name _____	Parent/Guardian Name _____
Address, If not living with student Receive Copy of Mail ○ Yes ○ No _____ Street Address, City, Zip Code	Address, If not living with student Receive Copy of Mail ○ Yes ○ No _____ Street Address, City, Zip Code
Home Phone: Cell Phone:	Home Phone: Cell Phone:
Parent's E-Mail: _____	Parent's E-Mail: _____
Employer: Work Phone:	Employer: Work Phone:

In case the student's parent/guardian cannot be reached, the school will contact and/or release the student to the following adults.

ADULT NAME	DAY-TIME PHONE	CELL PHONE	RELATIONSHIP TO STUDENT

PLEASE COMPLETE REVERSE SIDE OF EMERGENCY CARD

Siblings: _____ _____
Names/Ages/Schools **Names/Ages/Schools**

Siblings: _____ _____
Names/Ages/Schools **Names/Ages/Schools**

Siblings: _____ _____
Names/Ages/Schools **Names/Ages/Schools**

Check any of the following programs in which the student has currently enrolled:

☐ **Special Education** ☐ **GATE (gifted)** ☐ **Section 504 Accommodations** ☐ **Bilingual**

Health History:

Family Physician: _____
(Name) **(Phone)**

Allergic Reactions: Yes ☐ No ☐ If yes, type of allergy:
Asthma: Yes ☐ No ☐ If yes, medication taken, if any:
Seizure Disorder Yes ☐ No ☐ If yes, type:
Diabetes: Yes ☐ No ☐ Tetanus - Date of last immunization:
Medication Taken: Yes ☐ No ☐ If yes, name: _____ Times of day Taken:
Medication Taken: Yes ☐ No ☐ If yes, name: _____ Times of day Taken:

Note: If your child needs to take medication during school hours, a form must be signed by the parent AND the physician before the school can administer medications.

OTHER MEDICAL CONDITIONS:

Health Insurance Carrier: _____ Policy Number: _____

I/WE authorize the District's authorized personnel to administer first aid and to obtain medical care for my child, _____ In the event of an accident, injury, or illness.

I/WE the parents of _____ a minor, authorize the El Dorado Union High School District to act as my/our agent in my/our absence to obtain through the physician named above such as medical or hospital care as is reasonably necessary for the welfare of the student, including necessary transportation. In the event said physician is not available at the time, I authorize such care and treatment to be performed by any licensed physician or surgeon. I/WE agree to bear all costs incurred as a result of the foregoing.

_____ _____
Father / Guardian Signature **Date** **Mother / Guardian Signature** **Date**