FUSD Student Emergency Information Card

Form #95

Child's Name:	Date Enrolled:	Updated:
Home Address (#, Street, City):		Date Disenrolled:
Home Phone: ( )	Date of Birth:	Gender: ❑ Male ❑ Female

Mother or Guardian Name:	Home Address (#, Street, City):	Home Phone: ( )
Cell Phone: ( )	Work Address (#, Street, City):	Work Phone: ( )
Father or Guardian Name:	Home Address (#, Street, City):	Home Phone: ( )
Cell Phone: ( )	Work Address (#, Street, City):	Work Phone: ( )

To serve your child in case of accident or sudden illness, it is necessary that you furnish accurate information on individuals to call in an emergency. At least two of these individuals need to be within the FUSD geographic area. It is your responsibility to update this information as needed.

I authorize the following individuals to collect my child from the school if I cannot be located:

Name:	Address (#, Street, City):	Phone: ( )
Name:	Address (#, Street, City):	Phone: ( )
Name:	Address (#, Street, City):	Phone: ( )

The following individual(s) may NOT remove my child from the school:

Name(s):

Custody papers have been provided and are on file at the school. ❑Yes ❑No

Name(s) of other children in this school:

Last Name:	First Name:	Grade:	Teacher:
Last Name:	First Name:	Grade:	Teacher:
Last Name:	First Name:	Grade:	Teacher:

If Medical care is necessary, CALL:

Doctor	Name:	Address (#, Street, City):	Phone ( )
Hospital	Name:	Address (#, Street, City):	Phone ( )

List child's medication allergies:
Does your child have a continuing medical problem? ❑Yes ❑No Describe:
Does your child have insurance coverage? ❑Yes ❑No Name of Insurance Company: Policy #:

Bus Student ❑Yes ❑No Bus #_____ to school Bus # _____home	I, the undersigned, do hereby authorize officials of Flagstaff Unified School District to contact directly the persons named on this card. I will not hold the district financially responsible for the emergency care and/or transportation for this child. I consent to medical treatment by authorized pre-hospital personnel, members of the hospital staff and/or my child's medical provider in the event I cannot be notified first. Signature of Parent or Guardian:

Last Name _____ First Name _____ Grade _____ School _____ Teacher _____

Medical Information

Is child allergic to food or other substances?**If yes**, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:	❑Yes ❑No
Is child usually susceptible to infections and if so, what precautions need to be taken?**If yes**, list precautions:	❑Yes ❑No
Is child subject to convulsions and what should be our procedure if one occurs?**If yes**, list precautions:	❑Yes ❑No
Is there any physical condition that we should be aware of (i.e., heart trouble, foot problem, hearing impairment, hernia, etc.)?**If yes**, list precautions that should be taken:	❑Yes ❑No
Additional comments:	
Other special instructions:	

This **Emergency Information Card** is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	**SIGNED Name:**	**DATE**

Consent for Medical/Surgical Emergency Treatment and Medical Information

In presenting my/our ❑Son ❑Daughter (Name)_____, born _____, for diagnosis/treatment, I/we as parents/guardians, hereby voluntarily consent to the rendering of such care and medical treatment, including diagnostic procedures and blood transfusions, by authorized pre-hospital personnel and members of the hospital staff, as may in their professional judgment be necessary or in the best interest of my child.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on child's condition.

I have read this form and I certify that I understand its contents.

In addition, I/we hereby give my/our consent to Flagstaff Unified School District who will be responsible for my/our son/daughter during the school day (and/or authorized on-site before/after-school programs) to arrange for routine or emergency medical/dental care and treatment necessary to preserve the health of my/our child for as long as he/she is enrolled as a student in the district.

I/we acknowledge that I am/we are responsible for all reasonable charges in connection with care and treatment rendered during this period.

Signature: _____ ❑Mother ❑Father ❑Legal Guardian Date: _____

Witness: _____ Date: _____