CALIPATRIA UNIFIED SCHOOL DISTRICT

STUDENT HEALTH CARE & EMERGENCY TREATMENT FORM

I. STUDENT INFORMATION AND EMERGENCY CONTACTS

1. Last name (LEGAL NAME ONLY)	First	Middle	**2.** Birth date / /	**3**. Gender ❑ M ❑ F

4. Home phone ( )	**5.** Residence address	City	State	Zip
Parent/Guardian must provide immunization records to school office.	**6.** Mailing address (P.O. box or street # and name)	City	State	Zip

7. Father/Stepdad/Legal Guardian for Medical Consent
Name Contact Phone: ( ) Employed by: Work Phone: ( )

8. Mother/Stepmother/Legal Guardian for Medical Consent
Name Contact Phone: ( ) Employed by: Work Phone: ( )

9. Emergency Contact for Emergency and Medical Care Release
Name Contact Phone: ( ) Address City

II. PHYSICIAN INFORMATION

10. Family Doctor	**11.** Doctor's Address	City	State	Zip
12. Doctor's Telephone ( )	**13.** Preferred Emergency Care Provider/Hospital	City	State	Zip

Please respond to the following questions and provide health care provider information.

14. Does your child wear contacts or eyeglasses? ❑ Yes ❑ No	**15.** Name of Eye Care Provider	City	State	Zip
16. Does your child wear a hearing aid? ❑ Yes ❑ No	**17.** Name of Hearing Provider	City	State	Zip
18. Is your child currently under the care of a physician for other medical needs? ❑ Yes ❑ No	**19.** Name of Provider	City	State	Zip

III. MEDICAL INFORMATION

20. Please check the medical needs and history of your child

❑ Allergies	❑ Chicken Pox	❑ Headaches / Migraines
❑ Anemia	❑ Diabetes	❑ Heart Problems
❑ Asthma	❑ Ear / Hearing Problem	❑ Hepatitis
❑ Bladder Problems	❑ Epilepsy Seizures	❑ Intestinal / Stomach Disorder
❑ Blood Pressure	❑ Eye / Vision Problems	❑ Kidney Problems
❑ Broken bone(s)	❑ Fainting Spells / Dizziness	❑ Physical Disability
❑ Cancer	❑ Frequent Strep Throat	❑ Skin Problems
❑ Cerebral Palsy	❑ Frequent Nosebleeds	❑ Other _____

21. Please report any significant illness, hospitalizations or surgeries your child has undergone or are pending, include the date:

22. Please report any medications your child is currently taking:
Medication:_____ Dosage:_____ Medical Condition:_____
Medication:_____ Dosage:_____ Medical Condition:_____

All students needing any medication administered at school <u>MUST</u> have proper forms filed in the school office.
These forms need to be completed by your child's physician and returned to the school office.

23. Other medical information, limitations, or restrictions your child may have:

Notification/Consent for Medical Treatment: In the event that my child should become seriously ill or injured and the school officials are unable to contact us (parent/guardian or Emergency contact person), school officials may seek reasonable medical treatment for my student as needed, unless the parent/guardian has filed with the district a written objection to any medical treatment other than first aid.

Signature of Parent/guardian:	**Date:**