BONITA UNIFIED SCHOOL DISTRICT - EMERGENCY /HEALTH INFORMATION

STUDENT'S LEGAL NAME: _____ (Last / First / MI) ☐Boy ☐Girl Birthplace: City _____ State_____ Country_____

Birthdate: ____/____/____Age:_____ Grade: _____

Address: _____Apt/Sp#____City: _____Zip: _____Home Phone # ( ) _____

Student Lives With (Name) _____ Relationship _____

Employers Name: _____

Work Number With Extension # _____ Cell # _____

Student Lives With (Name) _____ Relationship _____

Employers Name: _____

Work Number With Extension # _____ Cell # _____

List in order of preference to whom you want your child released when you are not available.

Name # 1 _____ Address _____ Day time Phone # _____

Name # 2 _____ Address _____ Day time Phone # _____

Is your child currently covered by: Medical Insurance ☐ Yes ☐ No Dental Insurance ☐ Yes ☐ No Vision Insurance ☐ Yes ☐ No

Indicate Your Child's Medical Problems:

	Yes	No		Yes	No		Yes	No
Heart Problems	☐	☐	Counseling	☐	☐	Life Threatening Allergies	☐	☐
ADD/ADHD	☐	☐	Diabetes	☐	☐	If yes: List Allergen /Treatment_____		
Allergies	☐	☐	Epilepsy/Seizures	☐	☐			
Asthma	☐	☐	Date of last seizure _____			Osgood Schlatter Disease	☐	☐
Chicken Pox	☐	☐	Hearing Problems (Circle: Left/Right)	☐	☐	Skin Disorder	☐	☐

Significant Medical Problems: (describe) _____

List Surgeries/Hospitalization: (past 5 years) _____

List All Medication including Dosage: _____

I HEREBY AUTHORIZE AN EXCHANGE OF CONFIDENTIAL MEDICAL INFORMATION TO THE SCHOOL STAFF ☐ YES ☐ NO INITIALS _____

California Education Code 49076 Civil Code 56.10 and Health Insurance Portability and Accountability Act (H.I.P.A.A.) of 1996

A COPY OF THIS CARD WILL BE GIVEN TO THE PARAMEDICS WHEN THEIR EMERGENCY SERVICES ARE REQUIRED. I GIVE PERMISSION FOR ANY NECESSARY TREATMENT /MEDICATION TO BE ADMINISTERED TO MY CHILD BY THE ATTENDING PHYSICIANS/NURSES/HOSPITAL/PARAMEDICS.

Date _____ Signature: Father/Legal Male Guardian _____ Signature: Mother/Legal Female Guardian _____