

BONITA UNIFIED SCHOOL DISTRICT - EMERGENCY/HEALTH INFORMATION

STUDENT'S LEGAL NAME: _____ 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 # _____
 () _____ () _____
 Pager Number Cell Phone Number

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 Employers Name: _____
 Work Number With Extension # _____
 () _____ () _____
 Pager Number Cell Phone Number

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 #

Name of Medical Care Provider _____ Medical Group # _____

Indicate Your Child's Medical Problems.

	Yes	No		Yes	No
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures (date of last seizure)	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Glasses/Contacts (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Bee Sting/ Insect Bite Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems (circle: left/ right)	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Counseling	<input type="checkbox"/>	<input type="checkbox"/>	Osgood Schlatter Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>

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

I GIVE THE SCHOOL PERMISSION TO BILL MEDI-CAL/HEALTH INSURANCE FOR MEDICAL SERVICES RENDERED AT SCHOOL YES NO

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