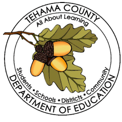


Tehama County Department of Education: Special Schools & Services

For Office Use Only	School/Program:	SSID:	Date Received:

STUDENT EMERGENCY FORM (Please Print)

Date of Birth

/ /

Last Name | First Name | Middle Name | (mm/dd/yyyy)

☐ Male ☐ Female Grade ____

Primary Household Information

RESIDENCE- Where is your child/family currently living? (Federally mandated by NCLB: check appropriate)

- ☐ Single family permanent residence (house, apartment, condo, mobile home)
- ☐ In a motel/hotel
- ☐ Doubled up (sharing housing with other families/individuals due to economic hardship, loss, or other reasons
- ☐ Unsheltered (car/campsite)
- ☐ In a sheltered or transitional housing program
- ☐ Other

With whom does the student reside? (check all that apply)

☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather
☐ Grandparent ☐ Foster Parent ☐ Care Giver ☐ Other:
☐ Group Home ☐ Court Appointed Guardian

Home Phone Number

( ) ____________

☐ **Name of Mother/** ☐ **Stepmother/** ☐ **Guardian** **(check relationship)** Phone Number ☐ cell ☐ work

( )

Home Address (Number and Street) | **City** | **Zip Code**

Mailing Address (If Different) | **City** | **Zip Code**

Email Address:

☐ **Name of Father/** ☐ **Stepfather/** ☐ **Guardian** **(check relationship)** Phone Number ☐ cell ☐ work

( )

Home Address (Number and Street) | **City** | **Zip Code**

Mailing Address (If Different) | **City** | **Zip Code**

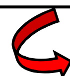
Email Address:

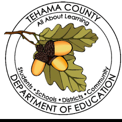
EMERGENCY CONTACT INFORMATION

Please list two contacts in the order they should be called OTHER than primary household

Name:	Relationship	Phone Number ( )	☐cell	☐ work
Name:	Relationship	Phone Number ( )	☐cell	☐ work
Name:	Relationship	Phone Number ( )	☐cell	☐ work

Please turn page over and complete information on reverse side





Tehama County Department of Education: Special Schools & Services

TRANSPORTATION HEALTH INFORMATION

For Office Use Only School/Program: District of Residence:
District Request for Transportation Sent: Received:

Please check either yes or no to specify if your child uses any of the following equipment.

Wheelchair	☐Yes	☐No	**Bellyband**	☐Yes	☐No	**Car Seat**	☐Yes	☐No
Harness	☐Yes	☐No	**Vest**	☐Yes	☐No	**Walker**	☐Yes	☐No

Other-please specify:

IMPORTANT MEDICAL INFORMATION

- ☐ Breathing Problems
- ☐ Scoliosis/"Rod" surgery
- ☐ Scoliosis/Brace
- ☐ Diabetes
- ☐ Blind/Visually Impaired
- ☐ "Fragile Bones"
- ☐ Other:
- ☐ Cerebral Palsy
- ☐ Gastrostomy Tube
- ☐ Asthma
- ☐ Seizures
- ☐ Heat Condition
- ☐ Deaf/Hearing Impaired
- ☐ Tracheotomy
- ☐ Shunt(s)
- ☐ Challenging Behavior
- ☐ Non-Verbal
- ☐ Non-Verbal but understands what is said

Transportation requested for:

AM	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ No transportation needed
PM	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ No transportation needed

Pick up/Drop off Location: ______________________________

AUTHORIZATION TO TREAT A MINOR: I hereby authorize and give my consent for emergency medical or dental care due to serious injury or illness if my designee or I cannot be reached. The physician named will be contacted or the child will be taken to an emergency room licensed under the Medicine Practice Act, at my expense. (Section 25.8 of the Civil Code of California)

Physician/Hospital: ______________________________ (   ) ____________

Name Phone

______________________________ (   ) ____________ ____________

Parent/Guardian's Signature for Authorization of Emergency Care — Phone Number — Date

I certify that all the information on this form is true and correct.

______________________________ ____________

Parent/Guardian's Signature — Date

Revised 4/2018