

SANTA MONICA HIGH SCHOOL STUDENT EMERGENCY CARD 2010-11

Please complete all parts of this form and sign below. If your child becomes ill or is injured while on this school-approved trip, it is important that information on this card is accurate and complete. Information will be kept confidential.

Students Full Name _____ DOB _____

Telephone () _____

Address _____ City _____ Zip _____

Male Female ID# _____ Grade _____ / _____ / _____ () _____

Student's Birth Date _____ Students Cell Phone

() _____ (if taking)

() _____ () _____

Father's Name (Or Guardian) _____ Father's WORK Phone _____ Father's CELL Phone _____

() _____ () _____

Mother's Name (Or Guardian) _____ Mother's WORK Phone _____ Mother's CELL Phone _____

STUDENT LIVES WITH: Mother Father Both Guardian Joint Custody

NAME of Health Insurance Carrier _____ Subscriber _____

Group # _____ Telephone Number () _____ MediCal# _____

Identify any health problems that your child has or may experience while away:

LAST TETANUS BOOSTER (month/year): _____ / _____ **LAST MEDICAL EXAM** (month/year): _____ / _____

AUTHORIZATION FOR MEDICATION – Medication will not be given without your signature. If left blank or crossed out, medication will NOT be made available to your child. I hereby request and authorize that the Chaperones make available the following medication(s) as directed by the SMMUSD physician consultant:

Medication (cross out if you do NOT want given)	Dose (same for either Meds)	Frequency	Parent Signature - Required
Acetaminophen (Tylenol) 325mg tablet	1 tablet if student weighs less than 100 pounds	By mouth Every 4-6 hours	x
Ibuprofen (Motrin, Advil) 200mg tablet	2 tablets if student weighs more than 100 pounds		x

ALLERGIES: Describe completely any allergies and/or reactions your child may have to any **FOOD** or **MEDICATIONS**. **IF YOUR CHILD HAS ANY LIFE THREATENING REACTIONS**, please make sure instructions are included and treatment described (include food and medicine allergies):

Physician _____ Address _____ Phone () _____

Dentist _____ Address _____ Phone () _____

IN THE EVENT OF A MEDICAL EMERGENCY, if I cannot be reached, I hereby give consent for my child to be transported to an Emergency facility and to receive necessary medical attention from a licensed physician, practitioner or dentist.

SIGNATURE of parent or legal guardian _____ **Date** _____

PRINT name of parent or legal guardian _____

EMERGENCY CONTACTS: If parents cannot be reached, the school is **ONLY** authorized to release your child to the below persons. Please supply the names of **AT LEAST** 2 persons who will know how to reach you in case of an emergency.

Name _____ Relationship _____ Address _____ Phone (day/eves) _____

1. _____

2. _____

3. _____