

FILL IN BOTH SIDES  
OF CARD

ILLNESS AND ACCIDENT PROCEDURE CARD  
Clovis Unified School District

SIGN CARD  
ON BACK

Form 15  
Revised 2/05

**\*\*NOTE: This card must be completed and signed by the student's Father, Mother or Guardian\*\***

SID# \_\_\_\_\_ Grade \_\_\_\_\_ Room/Counselor \_\_\_\_\_  
STUDENT'S NAME \_\_\_\_\_ Student's Birthdate \_\_\_\_\_ Male  Female   
Last Name First Name Middle Name

HOME ADDRESS \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ (If Same, Write "Same")

IN CASE OF SUDDEN ILLNESS OR ACCIDENT TO THIS STUDENT

1<sup>st</sup> Contact \_\_\_\_\_ Name of Father, Mother or Guardian (please circle one) Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Place of Employment \_\_\_\_\_ Work Hours \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_

2<sup>nd</sup> Contact \_\_\_\_\_ Name of Father, Mother or Guardian (please circle one) Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Place of Employment \_\_\_\_\_ Work Hours \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_

3<sup>rd</sup> Contact \_\_\_\_\_ Name of Step-Father or Step-Mother (please circle one if applicable) Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_

4<sup>th</sup> Contact \_\_\_\_\_ Name of Other Relative or Neighbor (please circle one) Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_

MEDICAL INFORMATION

This student has the following health condition(s): (Check all that apply to this student.)

- Glasses/Contacts  Heart Condition  Epilepsy/Seizure Disorder  Medication Allergy  Serious Accident  
 Hearing Difficulty  Asthma  Tuberculosis  Food Allergy  Diabetes  
 Serious Illness  Bleeder  Other \_\_\_\_\_

School nurse may notify school personnel of medical concerns of any checked (✓) information.

Parent/Guardian signature: \_\_\_\_\_

Date: \_\_\_\_\_

CONTINUING MEDICATION REGIMEN FOR NONEPISODIC CONDITION: REQUIRED NOTICE TO SCHOOL EMPLOYEES (Ed. code 49480)

The parent or legal guardian of any public school pupil on a continuing regimen for a nonepisodic condition, shall inform the school nurse or other designated certificated school employee of the medication being taken, the current dosage, and the name of the supervising physician. With the consent of the parent or legal guardian of the pupil, the school nurse may communicate with the physician and may counsel with the school personnel regarding the possible effects of the drug on the child's physical, intellectual, and social behavior, as well as possible behavioral signs and symptoms of adverse side effects, omission, or overdose. The superintendent of each school district shall be responsible for informing parents of all pupils of the requirements of this section.

IF YOUR CHILD IS TAKING MEDICATION REGULARLY, FILL OUT THIS SECTION

My child \_\_\_\_\_ Name of Child \_\_\_\_\_ Grade \_\_\_\_\_ is taking \_\_\_\_\_ Name of Drug \_\_\_\_\_ Dosage \_\_\_\_\_

ordered by \_\_\_\_\_ Name of Supervising Physician \_\_\_\_\_ Telephone Number \_\_\_\_\_ The school nurse may call the doctor and notify the school personnel regarding the effects of the drug.

SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

The undersigned, legal custodian of \_\_\_\_\_, a minor, hereby authorizes the principal of designee into whose care the aforementioned minor pupil has been entrusted, to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis, treatment, and/or hospital care to be rendered to said minor upon the advice of any licensed physician and/or dentist.

It is understood that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary.

This authorization is given pursuant to the provisions of Section 6910 of the California Family Code, and shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand that the Clovis Unified School District, its officers and its employees assume no liability of any nature in relation to the transportation of the said minor. I further understand that all costs of paramedic transportation, hospitalization, and any examination, x-ray or treatment provided in relation to this authorization shall be borne by the undersigned.

I understand that the Clovis Unified School District does not provide medical or accident insurance for students for school related injuries. I have received and read the student accident insurance information sent home for my child.

I authorize the release of medical information by the school district to its billing agency and to my insurance company as necessary to process a claim or request reimbursement for medical services rendered to my child. Any shared information will be limited to service documentation only.  YES  NO

Family Physician: \_\_\_\_\_ Telephone \_\_\_\_\_

PLEASE CHECK ONE:

th Insurance/MEDI-CAL: \_\_\_\_\_

My child is currently insured.  I will insure my child.

Group/Policy No./MEDI-CAL ID No.: \_\_\_\_\_

I choose not to insure my child.

SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

The signature on this card of the parent or guardian acknowledge receipt of Notice of Rights of Parents or Guardians of Minor Pupils pursuant to Education Code Section 48980; Board policies regarding Student Records and Sexual Harassment; and of letters regarding Emergency Procedures and Asbestos Management.

Si tiene alguna pregunta o si necesita la ayuda de un interprete, favor de llamar a la oficina de su escuela.  
Yog koi muai lus nuz loz vog xav tau neez pab txhais lus, thov hu rau koj lub tsev kawm ntawv.

Revised 02/05