STUDENT'S NAME _____
Last Name First Name Middle Name

SIGN CARD AT BOTTOM

ILLNESS AND ACCIDENT PROCEDURE CARD

Golden Valley Unified School District

Student's Birthdate _____ Male ☐ Female ☐

HOME ADDRESS _____ Home Phone _____
Street City Zip

MAILING ADDRESS _____ E-MAIL ADDRESS _____
(If Same, Write "Same")

School _____ Grade _____ Teacher _____

IN CASE OF SUDDEN ILLNESS OR ACCIDENT TO THIS STUDENT, ONLY THOSE LISTED ON THIS CARD MAY CHECK THE STUDENT OUT

1. Contact _____ Home Phone _____ Cell Phone _____
☐ Parent ☐ Step-Parent ☐ Guardian ☐ Foster Parent ☐ Other _____
_____ Work Phone _____
Place of Employment Work Hours

2. Contact _____ Home Phone _____ Cell Phone _____
☐ Parent ☐ Step-Parent ☐ Guardian ☐ Foster Parent ☐ Other _____
_____ Work Phone _____
Place of Employment Work Hours

3. Contact _____
☐ Parent ☐ Step-Parent ☐ Guardian ☐ Foster Parent ☐ Other _____
_____
Place of Employment Work or Cell Phone

4. Contact _____
☐ Parent ☐ Step-Parent ☐ Guardian ☐ Foster Parent ☐ Other _____
_____
Place of Employment Work or Cell Phone

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
☐ Hearing Difficulty ☐ Asthma ☐ Tuberculosis ☐ Food Allergy (Please list) _____
☐ Serious Illness ☐ Bleeder ☐ Other _____
☐ Serious Accident ☐ Diabetes

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

➔ SIGNATURE OF PARENT _____ DATE _____

The signature on this card of the parent or guardian acknowledges 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 letters regarding Emergency Procedures and Asbestos Management.

I have read & do understand the policies as outlined in the Student-Parent Handbook. ☐ YES ☐ NO

I give permission for my child's name, photo and/or other directory information to be used in district publications and local media. ☐ YES ☐ NO

Si tiene alguna pregunta or si necesita la ayuda de uninterprete, favor de llamar a la oficina de su escuela.

PLEASE COMPLETE BOTH SIDES OF THIS CARD

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

The parent or legal guardian of any school pupil on a continuing medication 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 *(Please include ALL medications taken)*

☐ My child takes no medication.

School nurse may call the doctor and notify the school personnel regarding the effects of the drug.

_____ _____
Name of Drug Dosage Name of Supervising Physician Phone

_____ _____
Name of Drug Dosage Name of Supervising Physician Phone

_____ _____
Name of Drug Dosage Name of Supervising Physician Phone

The undersigned, legal custodian of _____, a minor, hereby authorizes the principal or 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 of 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 Golden Valley Unified School District, its officers and its employees assume no liability of any nature in relation to the transportation of 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 Golden Valley 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.

Family Physician _____ Telephone _____

Health Insurance/MEDI-CAL _____

Group Policy No./MEDI-CAL ID No. _____

PLEASE CHECK ONE:

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

☐ I choose not to insure my child.