



Paramount Unified School District Emergency/Medical Information

Homeroom Teacher: _____

Student Legal Last Name		Student Legal First Name		Student Legal Middle Name		<input type="checkbox"/> Female	Date of Birth	Grade		
						<input type="checkbox"/> Male				
Residence Address			Apt #	City	State CA	Zip Code	Student Email			
Parent Last Name	First Name	<input type="checkbox"/> Mother <input type="checkbox"/> Father	Home Phone	Cell Phone	Work Phone	Email				
Contact allowed: <input type="checkbox"/> Yes <input type="checkbox"/> No		Educational Rights: <input type="checkbox"/> Yes <input type="checkbox"/> No		Has Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No		Lives with: <input type="checkbox"/> Yes <input type="checkbox"/> No		Mailing allowed: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Parent Last Name	First Name	<input type="checkbox"/> Mother <input type="checkbox"/> Father	Home Phone	Cell Phone	Work Phone	Email				
Contact allowed: <input type="checkbox"/> Yes <input type="checkbox"/> No		Educational Rights: <input type="checkbox"/> Yes <input type="checkbox"/> No		Has Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No		Lives with: <input type="checkbox"/> Yes <input type="checkbox"/> No		Mailing allowed: <input type="checkbox"/> Yes <input type="checkbox"/> No		
United States Armed Forces: (Required annually by US Department of Education)										
Is either parent/guardian on Active Duty in the Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No			If Armed Forces, which branch: <input type="checkbox"/> Air Force <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Marine Corps <input type="checkbox"/> Navy							
Is either parent/guardian on Full-time National Guard Duty? <input type="checkbox"/> Yes <input type="checkbox"/> No			If National Guard, which branch: <input type="checkbox"/> Army National Guard <input type="checkbox"/> Air National Guard							
Legal Guardian Last Name	First Name		Home Phone	Cell Phone	Work Phone	Email				
<input type="checkbox"/> Step Father		<input type="checkbox"/> Step Mother		<input type="checkbox"/> Court Appointed Guardian		<input type="checkbox"/> District Authorized Guardian		<input type="checkbox"/> Caregiver	<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Group Home

IN CASE OF EMERGENCY: Names of persons who can assume temporary responsibility.

Name	Relationship	Home Phone	Work Phone	Other phone
Name	Relationship	Home Phone	Work Phone	Other phone
Name	Relationship	Home Phone	Work Phone	Other phone
Out of State Emergency Contact Person			Out of State Emergency Phone Number	

List person(s) who may not take your student from school: _____ Name: _____ Name: _____
 Is there a court order? Yes No

Does your student attend a before school program? Yes No Name of program: _____
 Does your student attend an after school program? Yes No Name of program: _____
 Number of children in the family (include children not attending school): _____ List school age brothers and sisters below:

Name	DOB	School	Grade	Name	DOB	School	Grade

Please check the appropriate box, if any, of the the following that apply to the student and give a brief explanation in the space provided below. List all health conditions including those from previous years. Please notify the school office at your student's school of any changes in your student's health condition or change of medication.

- | | | | | | |
|------------------------------------|--|---|--------------------------------------|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> High fevers | <input type="checkbox"/> Serious accident | <input type="checkbox"/> No known health problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Migraines | <input type="checkbox"/> Surgery | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Disabilities | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Seizures | <input type="checkbox"/> Vision Problems | |

Explanation: _____

ALL MEDICATIONS OR INHALERS GIVEN AT SCHOOL (prescribed or over the counter) REQUIRE AN AUTHORIZATION FOR ANY MEDICATION TAKEN DURING SCHOOL HOURS FORM WHICH MUST BE RENEWED ANNUALLY OR WHEN CHANGING MEDICATION. DOSE, TIME OR ROUTE. (Forms available in school office)

Medical Information – (Check all that apply)

Is your student currently taking any medication at home? Yes No List name and dose: _____

Does your student currently need any medication at school: Yes No List name and dose: _____

Has your student had an allergic reaction to the following: None Nuts Insect stings Explain: _____

Epinephrine Injection (Epipen)? Yes No

List any other restrictions your student has: _____

Do you currently have health insurance? Yes No Do you currently have Medi-Cal? Yes No

Physician Name:	Phone:	Ext.	Hospital:
Insurance Company (if applicable):	Phone:	Ext.	Patient ID#:

I, the undersigned parent/guardian, give my consent for the above named student to be released to me or my spouse or to the friend/relative I have so designated and/or to be taken by ambulance to the nearest hospital in case of emergency. I understand that Paramount Unified School District does not provide accident medical/dental coverage for students for injuries/illnesses occurring at school. I understand that I may voluntarily purchase a student accident insurance plan. I further acknowledge that I am financially responsible for medical, dental, ambulance, or other health care expenses or transportation of my student, which might occur as a result of such illness or injury.

Signature of Parent/Legal Guardian: _____ Date: _____

PLUSD Student Registration (REV 3/13)
Spanish version available upon request
Form R-4 of 5

Review immediately for medical alerts/legal notifications. Add/revise in Synergy and file in office.