



ROBERT F. KENNEDY HIGH SCHOOL
DELANO JOINT UNION HIGH SCHOOL DISTRICT
EMERGENCY INFORMATION FORM

Please complete the following and return to school:

Student ID#

\_\_\_\_\_

Legal Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Current Grade: \_\_\_\_\_

Last School Attended: \_\_\_\_\_ Language spoken at home: \_\_\_\_\_

Student lives with: Both Parents \_\_\_ Father \_\_\_ Mother \_\_\_ Guardians \_\_\_

Is there a court order restricting a parent from visiting/removing this child from school: Yes \_\_\_ No \_\_\_
(If "yes", present the recorded court order to the attendance office to have a photocopy made for the child's school files.)

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Mobile #: \_\_\_\_\_ Email: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Place of employment: \_\_\_\_\_ Work #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Place of employment: \_\_\_\_\_ Work #: \_\_\_\_\_

Please note that if your son/daughter needs to be picked up from school at any time during regular school hours by any individual other than the legal guardian or the parent, Attendance Office (720-5104, 720-5131, 720-5130, 720-5105) Staff need to receive a phone call from the legal guardian or parent or a note prior to the individual picking up the student.

In case my child is ill or there is an Emergency and I cannot be reached, you may call or release my child to:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Student's medical information:

Doctors Name: \_\_\_\_\_ Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Does your child have a diagnosed history of: (Check all that apply)

\_\_\_ Asthma \_\_\_ Convulsions/Seizures \_\_\_ Speech problems \_\_\_ Diabetes \_\_\_ Allergies (please list) \_\_\_\_\_

\_\_\_ Heart Problems \_\_\_ Hearing Problems \_\_\_ Vision Problems \_\_\_ A Shunt \_\_\_ Depression \_\_\_ Surgeries \_\_\_\_\_

Does your child wear eye glasses? Yes \_\_\_ No \_\_\_ Does your child wear hearing Aids? Yes \_\_\_ No \_\_\_

Does your child have any physical handicaps or special needs? Yes \_\_\_ No \_\_\_ (If "Yes" please explain) \_\_\_\_\_

\_\_\_\_\_

Has your child ever been in Special Education class? Yes \_\_\_ No \_\_\_ (if "Yes" Please explain) \_\_\_\_\_

Does your child take any medications regularly? Yes \_\_\_ No \_\_\_ (if "Yes" Please explain) \_\_\_\_\_

I authorize the school to act as agents to consent to an X-Ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practice Act for the above-named child. I hereby grant permission for the school personnel to transport my child as deemed necessary in an emergency, and/or supervised study trip.

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_