Yav Pem Suab Academy **Student Information**

Complete All Information on Both Sides **CONFIDENTIAL** ***Please Print***

Student's Last Name (Legal) First Name Middle

Date of Birth

School Year _____ School _____

Office Use Only
Teacher/Counsel. _____
Grade _____ Room _____ Bus _____
CONCAP ☐ Hm. Sch. _____
Sp. Ed. ☐ RSP ☐ Eth. Cd ☐

Street Address Apt #

Home Phone (1): _____ Home Phone (2) _____

Zip Code

Last School of Attendance _____ City _____

Father's Name (Guardian)

_____ *(Soc. Sec. #)* _____

Check One: Natural ☐ *Step* ☐ *Guardian/Foster* ☐ *Driver's Lic. #* _____

Place of Employment: Work Phone: _____
_____ Cell Phone: _____
_____ Pager: _____
E-mail address _____

Mother's Name (Guardian)

_____ *(Soc. Sec. #)* _____

Check One: Natural ☐ *Step* ☐ *Guardian/Foster* ☐ *Driver's Lic. #* _____

Place of Employment: Work Phone: _____
_____ Cell Phone: _____
_____ Pager: _____
E-mail address _____

Day Care Provider: _____ Phone #1: _____ Phone #2 _____

List names of other children attending this school:

School is authorized to share my phone number with the PTA:
Yes _____ No _____

Check here if student will be riding the bus: Yes _____
Bus Number: _____

Parent/Guardian with whom the child lives _____ **Phone #** _____

If the parents are divorced or separated, to whom has physical custody been given? (attach verification) _____

Please Read:
The parent/guardian is responsible for keeping the school informed of updates or changes to the student's emergency information. The school shall be notified, in writing, of telephone or address changes within three days (3) of the occurrence. If the school is unable to reach anyone on this card in an emergency or if a student is left unattended during non-school hours, the school will contact law enforcement or Child Protective Services.

I have read this and understand my responsibility. _____ *Parent / Guardian Signature*

Note: The adults listed below are authorized to pick up and care for the above-named student. The student may be released to others with written or verbal authorization.

Name 1: _____
Phone: _____ Relationship _____

Name 2: _____
Phone: _____ Relationship _____

Name 3: _____
Phone: _____ Relationship _____

Name 4: _____
Phone: _____ Relationship _____

Name 5: _____
Phone: _____ Relationship _____

Name 6: _____
Phone: _____ Relationship _____

Name 7: _____
Phone: _____ Relationship _____

Name 8: _____
Phone: _____ Relationship _____

Special instructions / comments / (Include instructions for pickup of student):

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General Health Information

Check here if there are no known health problems. ☐ Blood type, if known _____

Eyes: Wears glasses ☐ Glasses to be worn at all times ☐ Wears Contacts ☐ Requires preferential seating ☐

Comments:

_____

Ears: Known hearing problem ☐ Uses hearing aids ☐ Has tubes in ears ☐ Requires preferential seating ☐

Comments:

_____

Has the following condition(s):

Epilepsy ☐ Fainting Spells ☐ Diabetes ☐ Heart Condition ☐ Asthma ☐ Attention Deficit Disorder ☐

Severe bee sting allergy ☐ Describe:

_____

Other:

_____

Are any of the above life threatening? Yes ☐ No ☐ Please explain: _____

** Medicine prescribed on a regular basis: _____ Dosage: _____ Diagnosis: _____

*** Does the drug need to be taken during school hours? Yes ☐ No ☐ Prescribed by Dr. _____ Phone _____

Has condition that limits participation in: classroom ☐ physical education ☐ Explain: _____

_____ Under care of Dr. _____ Phone _____

Please Read:

*** California Education Code 49408 states that school districts may require that emergency information be kept current.**

**** The parent or legal guardian of a public school pupil on a continuing medication regimen shall inform the school nurse or other designated certificated employee of the medication being taken.**

***** California Education Code 49423 requires that if medications are to be taken at school, there must be a medication form on file at school, signed by both parent and physician.**

EMERGENCY AUTHORIZATION

In the event of an emergency, when a parent/guardian is unavailable, I authorize school personnel to make such arrangements for my child to receive medical/hospital care, including necessary transportation, in accordance with their best judgment. I further authorize the physician named below to undertake such care of my child, as he/she considers necessary. In the event said physician is not available, I authorize such care and treatment to be performed by a licensed physician or surgeon. I understand that the parent or guardian is responsible for the cost of such emergency care.

Physician Name _____ Phone _____ Pager _____

Emergency Facility/Phone _____

Name of Insurance Coverage or Health Plan Provider: _____ Student's Medical Record Number _____

I certify that the information is true and correct. ☐ Please Initial

Parent/Guardian Signature _____ **Date** _____

Special instructions / comments: List any special health needs or medical problems, including allergic reactions.

_____

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Student's Photograph