NAME Last First Middle

(______)__________________ HOME Phone (PRIMARY)

(_______)__________________ HOME Phone (ALTERNATE)

ADDRESS City Zip

☐ Male ☐ Female ID # _______________ Grade: ________

Father's Name (or Guardian's) Occupation

_______/_______/______ STUDENT's Birthdate (Mo/Da/Yr)

(_______)__________________ STUDENT's Cell phone (if taking)

Father's Employer

(_______)__________________ Father's WORK Phone

(_______)__________________ Father's CELL Phone

Father's Work Address City

(______)__________________ Father's PAGER

__________________ Father's EMAIL

Mother's Name (or Guardian's) Occupation

(______)__________________ Mother's WORK Phone

(_______)__________________ Mother's CELL Phone

Mother's Employer

(______)__________________ Mother's PAGER

__________________ Mother's EMAIL

Mother's Work Address City

LIVES WITH: ☐ Mother ☐ Father ☐ Guardian ☐ Joint Custody ____

**** WILL YOU BE OUT OF TOWN ?** ☐ NO ☐ YES: SPECIFY how we can reach you or whom we should contact____________________________

EMERGENCY CONTACTS : If parents cannot be reached, the school is ONLY authorized to release your child to these PERSONS (this includes upon our return on __________) : Please supply name of at least one person who will know how to reach you in case of an emergency **during travel dates:**

	Name	**Relationship**	**Address**	**Phone (Day/Eves)**
1.	______________________	__________	______________________	(_____)__________
2.	______________________	__________	______________________	(_____)__________
3.	______________________	__________	______________________	(_____)__________
4.	______________________	__________	______________________	(_____)__________

----- PLEASE PRINT ----- **STUDENT EMERGENCY CARD - SANTA MONICA HIGH SCHOOL – SMMUSD** ----- PLEASE PRINT ----

PLEASE complete ALL parts of this card and SIGN below. If your child becomes ill or is injured while on this school-approved trip, it is important that information on this card is accurate and complete. This card will be used ONLY for this school sponsored trip. Information will be kept confidential.

NAME of Health Insurance Carrier ______________________________ Subscriber # ______________________

Group # ______________ Telephone number (_______)______________ MediCal # ________________________

Identify any Health Problems____

MY CHILD IS SAFE TO SWIM : ❑ YES ❑ NO ______________________ **MY CHILD SLEEPWALKS** : ❑ YES ❑ NO
____

LAST TETANUS BOOSTER (month/year) : ______ / ______ **ALLERGIC TO** (Describe reaction): ______________________

IF YOUR CHILD HAS ANY LIFE-THREATENING REACTIONS, please make sure appropriate instructions are included & treatment described:
(include food and medication allergies)

CURRENT MEDICATIONS: <u>(For ALL medications except the over-the-counter medications listed below we MUST have the district medication form completed and accompanying this card)</u>. Please list the Medication Name, Dosage, Scheduled Time of Administration:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

ANYTHING THE CHAPERONES SHOULD BE AWARE OF THAT WAS <u>NOT</u> ADDRESSED ABOVE: (e.g. special dietary concerns; reactions; treatments)

Physician ____________________ Address____________________ Phone (______)______________ Date: Last exam ____/____/____

Dentist ____________________ Address____________________ Phone (______)______________ Date: Last exam ____/____/____

IN THE EVENT OF A MEDICAL EMERGENCY, if I cannot be reached, I hereby give consent for my child to be transported to an Emergency facility and to receive attention from a physician or dentist.

SIGNATURE of parent or legal guardian____ **Date** ____________________

COMPLETE BOTH SIDES OF THIS CARD! --- If any information changes prior to departure, provide IN WRITING at time of departure….

NOTES (for chaperones to complete as needed for communication) – continue on reverse if needed

The following non-prescription medications are sometimes needed when traveling, on an as needed basis. Please have your physician cross out the items your student should not take and sign the form in the appropriate block. You must also sign in the appropriate block. **<u>You must provide the medications the doctor approves.</u>**

Acetaminophen (Tylenol) 325 mg every four hours

Ibuprofen (Advil/Motrin) 400 mg every four to six hours

Diphenhydramine (Benadryl) as directed on box

Cold Medication ______________________

Benadryl gel lotion as directed

Immodium (for diarrhea) as directed on box

Tums as directed

Cough drops

Parent Signature ________________________ Date ______________________

Doctor Name ________________ Signature ________________________ Date __________