Form 1S
Revised 01/09

FOR THE HEALTH OFFICE

Clovis Unified School District Illness and Accident Procedure Card

NOTE*: *This card must be completed and signed by the student's Father, Mother or Guardian

SID# _____ Grade _____ Room/Counselor _____

STUDENT'S NAME _____ Birthdate _____ Male ❑ Female ❑
Last Name First Name Middle Name

HOME ADDRESS _____ Home Phone _____
Street City Zip

E-MAIL ADDRESS _____

IN CASE OF SUDDEN ILLNESS OR ACCIDENT TO THIS STUDENT

1st Contact _____ Home Phone _____ Work Phone _____
Name of Father, Mother or Guardian (please circle one)

_____ Cell Phone/Pager _____
Place of Employment Work Hours

2nd Contact _____ Home Phone _____ Work Phone _____
Name of Father, Mother or Guardian (please circle one)

_____ Cell Phone/Pager _____
Place of Employment Work Hours

3rd Contact _____ Home Phone _____ Work Phone _____ Cell Phone/Pager _____
Name of Step-Father or Step-Mother (please circle one if applicable)

4th Contact _____ Home Phone _____ Work Phone _____ Cell Phone/Pager _____
Name of Other Relative or Neighbor (please circle one)

MEDICAL INFORMATION - This student has the following health condition(s): ***(Check all that apply to this student.)***

❑ ADD/ADHD ❑ Asthma ❑ Bleeding Disorder _____ ❑ Diabetes ❑ Epilepsy/Seizure Disorder ❑ Heart Condition
❑ Glasses/Contacts ❑ Hearing Difficulty ❑ Medication Allergy to _____ ❑ Food Allergy to _____
❑ Serious Accident/Illness _____ on (date) _____ ❑ Other Health Concerns _____
Please explain any conditions checked: _____

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

PLEASE SIGN CARD ON BACK

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

The parent or legal guardian of any public school pupil on a continuing 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 <u>MEDICATION REGULARLY,</u> PLEASE FILL OUT THIS SECTION

My child _____ is taking _____
Name of Child — Name of Drug — Dosage

ordered by _____
Name of Supervising Physician — Telephone Number

The school nurse may confer with the doctor and notify school personnel regarding the child's condition and the effects of this medication when necessary.

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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 Clovis Unified School District, its officers and its employees assume no liability of any nature in relation to the transportation of the 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 Clovis 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.

I authorize the release of medical information by the school district to its billing agency and to my insurance company as necessary to process a claim or request reimbursement for medical services rendered to my child. Any shared information will be limited to service documentation only. ☐ **YES** ☐ **NO**

Family Physician: _____ Telephone _____ PLEASE CHECK ONE:

Health Insurance/MEDI-CAL: _____ ☐ My child is currently insured. ☐ I will insure my child.

Group/Policy No./MEDI-CAL ID No.: _____ ☐ I choose not to insure my child.

SIGNATURE OF PARENT OR GUARDIAN _____ **DATE** _____

Si tiene alguna pregunta o si necesita la ayuda de un interprete, favor de llamar a la oficina de su escuela.
Yog koj muaj lus nug los yog xav tau neeg pab txhais lus, thov hu rau koj lub tsev kawm ntawv.

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