KIDS CARE PLUS

EMERGENCY INFORMATION

[ ] CHABOT[ ] STANTON [ ]PRIMETIME
FAMILY ID # _____

LAST NAME	FIRST NAME	D.O.B	AGE (As of Sept 1st)	KCP USE ONLY
STREET ADDRESS CITY ZIP CODE		HOME PHONE ( )	GRADE (As of Sept 1st)	CLASS RM #
PARENT/GUARDIAN 1 NAME		PARENT/GUARDIAN 2 NAME		ANY ALLERGIES?
ADDRESS (If different)		ADDRESS (If different)		
HOME PHONE (if different)	CELL PHONE ( )	HOME PHONE (if different)	CELL PHONE ( )	ANY MEDICATIONS?
EMAIL		EMAIL		
PLACE OF EMPLOYMENT		PLACE OF EMPLOYMENT		OTHER?
WORK #	ALTERNATE#	WORK #	ALTERNATE#	

PLEASE LIST SIBLING(S) INFORMATION

NAME	AGE	GRADE	PHONE # (if applicable)	CVUSD STUDENT

PERSON(S) RESPONSIBLE FOR CHILD:

Please list a person in another state, or who lives 100 to 500 miles away, as a MUTUAL CONTACT PERSON, in case of a major disaster and we are unable to communicate with one another locally via phone.

NAME:	PHONE #:	ADDRESS:	RELATIONSHIP

Name of persons authorized to take child from the facility MUST PRESENT GOVERNMENT ISSUED IDENTIFICATION CARD UPON PICKING UP YOUR CHILD. Your child will not be allowed to leave with any other person without ***PRIOR written authorization*** from parent(s) or legal guardian's).

WE CANNOT ACCEPT AUTHORIZATION BY PHONE FOR YOUR CHILD TO BE PICKED UP BY ANYONE WHO IS NOT ON THIS LIST. EVEN IN CASE OF AN EMERGENCY.

THESE INDIVIDUALS YOU HAVE PROVIDED HAVE YOUR PERMISSION TO PICK UP YOUR CHILD AND/OR CALLED IN CASE OF AN EMERGENCY. *Please list them in the order you wish for them to called.*

NAME	*PHONE #*	*ADDRESS*	*RELATIONSHIP*

[OFFICE ORIGINAL] [SITE COPY]

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Medical History:

Does he/she have any allergies to medications, food, etc? [ ]YES [ ]NO If YES, Please_____

_____

Does he/she currently take any prescription medications? [ ]YES [ ]NO If YES, Please list them and the possible side

_____

Does he/she carry an inhaler for asthma? [ ]YES [ ]NO LIC 9166 Rec'd with doctor's note. Y/N

Does he/she use a Nebulizer? [ ]YES [ ] NO (If Yes LIC 9166 form must be given) Date_____

Does he/she carry an Epi-pen for allergies? [ ]YES [ ]NO If YES, Please list: _____

Does he/she have any chronic health concerns? [ ]YES [ ]NO If YES, Please list: _____

Has his/her physical activity been restricted during the past five years? Please explain: _____

PHYSICIAN and DENTIST to be called in an EMERGENCY:

Physician's Name | Telephone | Address

Dentist's Name | Telephone | Address

Health Care Provider: _____ Policy Number: _____

Name of Policyholder: _____ Is your policy a: [ ]HMO or [ ]PPO

Permission to Secure Treatment

The undersigned, as parent/legal guardian of the child registered on this form, hereby authorizes Kids Care Plus and its delegated staff to consent to any medical and hospital care to be rendered to said minor upon the advice of a licensed physician. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. It is understood that if time and circumstances reasonably permit, staff will endeavor, but is not required, to communicate with me prior to such treatment. The undersigned further agrees that Kids Care Plus and its designated staff are not legally or financially liable for any claim arising from any such consent given in good faith in connection with such diagnosis or advised treatment. This authorization and consent to treatment of a minor is given to Kids Care Plus in connection with any authorized daily activity or event.

_____ _____ _____

Name of Parent or Legal Guardian's (print) Signature of Parent or Legal Guardian's Date

Cell Phone Use:

I, the parent of the student named below, hereby authorize my child to use a cell phone at school.

I acknowledge that Kids Care Plus, its employees and assigns shall not be responsible for use, damage, the loss and/or theft of any cell phone or other personal electronic device which my child brings to or possesses at Kids Care Plus.

I understand that use of the cell phone will be allowed only during designated hours and in designated places.

Use of the cell phone or electronic device in an unauthorized place and/or manner will result in:

1. First Infraction: Student shall receive a warning.
2. Second Infraction: The device shall be confiscated for the day and be held in the office. It shall be returned to the student at the end of the school day once his or her parent is contacted.
3. Third Infraction: This privillage will be revoked

_____ _____ _____

Student Name **Student's Signature** **Cell Phone**

_____ _____ _____

Name of Parent or Legal Guardian's (print) Signature of Parent or Legal Guardian's Date

[OFFICE ORIGINAL] [SITE COPY]