

Bolinas-Stinson Union School

Emergency Information

Student _____ Grade: _____
Last First Middle Date of Birth

Father/Guardian _____
Name Home Phone Number Cell Phone Work Phone Number email address

Mailing Address Home Street Address City Zip Code

Mother/Guardian _____
Name Home Phone Number Cell Phone Work Phone Number email address

Mailing Address Home Street Address City Zip Code

If parents are not living together, are there any special custody restrictions? If yes, please describe _____
_____ and attach pertinent court documentation.

Please list siblings attending the Bolinas-Stinson School. 1. _____ 2. _____ 3. _____

If you cannot be reached, list three people whom we may contact/release your child to in case of illness, injury, emergency or disaster:

1.	Name	Relationship	Home Phone Number	Work Phone Number	Cell phone number
2.	Name	Relationship	Home Phone Number	Work Phone Number	Cell phone number
3.	Name	Relationship	Home Phone Number	Work Phone Number	Cell phone number
4.	Name	Relationship	Home Phone Number	Work Phone Number	Cell phone number

PARENT/GUARDIAN MUST SIGN EMERGENCY INFORMATION FORM Important: Please list below specific health problems/recommendations in case of accident or illness, including allergies or other information.

Physician _____
Name Phone Number

Dentist _____
Name Phone Number

Medication: If your child requires medication at school, all medication sent to the school must be in the prescription container with a current date and an "Authorization for Administration of Medication" must be on file before medication can be administered. (You may obtain the form from the school office.)

Please indicate:
Medication _____ Dosage _____ Hour(s) given _____

- _____ Yes _____ No I give the school personnel permission to give my child a non-aspirin pain reliever.
- _____ Yes _____ No I hereby give permission for all class trips.
- _____ Yes _____ No I have/will read the Parental Rights and policies section of the Student-Parent Handbook.
- _____ Yes _____ No Include us in the School Directory.
- _____ Yes _____ No Use my email for certain correspondence. If yes, please include email address/es above.

I/we hereby give permission to the school to obtain emergency medical care and necessary transportation if the school cannot reach me/us or my/our designated emergency contacts. I/we understand that the Bolinas-Stinson Union School District does not provide accident/medical insurance for students, and I/we further understand that all costs related to medical treatment shall be my/our responsibility and not the school district's.

_____ is the hospital I prefer for emergency medical treatment.
Hospital Name

I/we will notify the school office immediately of any changes to be made in the foregoing information.

Parent/Guardian (Signature) _____ Date _____