Antelope Valley Learning Academy
HERE FOR OUR KIDS
avlearning.org

Emergency Card

For (School Year):________________

Pupil's Last Name	Pupil's First Name	Grade	Age	Student ID#

Mailing Address: ______________ **City** ______________ **Zip** ______________

Physical Address: ______________ **City** ______________ **Zip** ______________

Directions to Residence:____

____

____

Person(s) authorized to pick up student from school:__[__]_Mother_____[_]_Father__________________

Other:____

Father's Name:______________________________ Mother's Name:______________________________

Daytime Phone:______________________________ Daytime Phone:______________________________

Cell Phone:______________________________ Cell Phone:______________________________

Employer:______________________________ Employer:______________________________

Work Phone:______________________________ Work Phone:______________________________

Email:______________________________ Email:______________________________

*Is there a custody issue regarding this student? Yes No
*Legal Restrictions for any parent are:

Court Order on file at school: Yes No
Proof of Custodial Agreement is required for enrollment.

Please list two neighbors/friends or nearby relatives who will assume temporary care of your child if you cannot be reached:

Name:____Telephone:______________________

Name:____Telephone:______________________

Other Children in Family:

Name of Siblings	Sex M/F	Year Born	School Currently Attending	Adults Other Than Parents Living In Home	Relationship to Student

HEALTH INFORMATION:
Medication taken by child at home - *(Written authorization from doctor is required for school to administer.)*

Please check any of the following that might apply to your child:
Vision: Known eye condition/defect in vision_____ Wears Glasses:______ Wears Contact Lenses:______
Glasses to be worn at all times:_______ Under the care of (list Dr.)_________________________
Hearing: Known hearing problem:________ Wears Hearing Aid:_______ Preferential Seating:__________
Under the care of (list Dr.)____

☐No known health problem or condition.
☐Has a condition which may result in classroom emergency, such as:
- ☐Asthma
- ☐Bee Sting Allergy
- ☐Epilepsy
- ☐Diabetes
- ☐Heart Condition
- ☐Known or Suspected Allergies:
- ☐Seizures:
- ☐Other:

What action is to be taken if your child has a complication due to his/her allergic condition or health condition? (Please be specific):____
____

In case of accident or other emergency, if parent or guardian cannot be reached, I hereby authorize a representative of the school to make such arrangements as he/she considers necessary for my child to receive medical or hospital care, including necessary transportation. Unde such circumstances, I further authorize the physician named below to undertake such acts and treatment of my child as he/she considers necessary. In the event said doctor is not available, I authorize such care and treatment to be performed by any licensed physician or surgeon.

____
Name of Physician: Address of Physician Physician's Phone

Insurance ID or Policy#_____________________________________

Health Insurance Carrier:___________________________________

Hospital Preference:_______________________________________

The undersigned hereby agree to bear all costs incurred as a result of the forgoing. This authorization will remain in effect until revoked by the undersigned in writing:

Date:____________________________________ Signature____
(Parent or Guardian)