

EMERGENCY CARD

PLEASE PRINT

Travis Unified School District
2751 DeRonde Drive, Fairfield, CA 94533-9710

Student Services
(707) 437-8214 Fax (707) 437-8254

School: _____ Grade: _____

Student Name: _____
Last First Middle

Current Address: _____ Sex: M F

City: _____ Zip Code: _____ Home Phone: _____

Birthdate: _____ Day Care Provider: _____ Phone: _____

Student resides with (please circle): Father Mother Stepfather Stepmother Guardian Foster Parent

Shared Custody _____ Military Rank (if applicable) _____

Non Resident Parent (Optional) _____
Name Address City State Zip Code

For Office Use Only

Teacher /Counselor _____
 Traditional _____ Year Round _____
 Confidential File
 Legal File
 Track _____
 Student ID _____
 IDA Yes _____ No _____

Father/Guardian:	Mother/Guardian						
Place of Employment:	Place of Employment						
Home Phone Cell Phone	Home Phone: Cell Phone:						
Work Phone Email	Work Phone: Email:						
IF YOU CANNOT BE REACHED, LIST LOCAL PERSONS AUTHORIZED TO ACT ON YOUR BEHALF							
1. Name:	Relationship to Student: Day Phone:						
2. Name:	Relationship to Student: Day Phone:						
3. Name:	Relationship to Student: Day Phone:						
Other Children in Family (<i>List Last Name if different</i>)							
<small>First</small>	<small>Last (if different)</small>	<small>Grade</small>	<small>School</small>	<small>First</small>	<small>Last (if different)</small>	<small>Grade</small>	<small>School</small>
1.				3.			
2.				4.			
Please circle if your child is OR has been enrolled in a: 504 Plan, Special Education Resource, Special Day Class, Speech, Other If not enrolled at present, list date dropped: _____							
Special Health Problems:				Prescribed Medication Taken:			
Do you have health insurance? Yes ___ No ___ Don't Know ___ The District does not provide medical, dental or accident insurance. If you are interested in purchasing a low cost plan contact Pacific Educators Inc. at www.peinsurance.com . Please read the Student Benefits Plan Brochure to select the plan that best meets your needs.				Insurance Company Group # / Student Medical #			
Physician: Phone:				Dentist: Phone:			

Name: _____
Last

First

Grade

If the listed persons cannot be reached, I give my consent for transportation and medical or dental treatment, including x-ray, examination, anesthetic, diagnosis, and hospital care to be rendered upon the advice of any licensed physician or dentist. **By signing this card I understand that the Travis Unified School District does not provide medical, dental or accident insurance for students.**

Signature of Parent/Guardian

Date

Additional information on back

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Disaster Sign Out

Use only in an emergency evacuation situation where students must be released during the school day. The student may only be released to a person listed on the front of this emergency card.

_____ **Print - Student Name**

_____ **Name of Person Picking up Student**

_____ **Signature**

_____ **Time Released**

_____ **Signature of Staff Member Releasing**

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