Boulder Valley School District
*Excellence and Equity*

# EMERGENCY INFORMATION

**Student Name** _____ _____ _____
Last First MI or nickname

**School Year** _____ **M F** **Birthdate** _____ **Grade**_____

Student lives with: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Joint Custody ☐ Other_____

| | | |
|---|---|---|
| Mother's Name:<br>_____<br>First Name<br>_____<br>Last Name | Mother's Address:<br>_____<br>Street<br>_____ _____ _____<br>City ZIP | Home (_____)_____<br>Work (_____)_____<br>Cell (_____)_____<br>Pager (_____)_____ |
| Father's Name:<br>_____<br>First Name<br>_____<br>Last Name | Father's Address:<br>_____<br>Street<br>_____ _____ _____<br>City ZIP | Home (_____)_____<br>Work (_____)_____<br>Cell (_____)_____<br>Pager (_____)_____ |

**Local Emergency Contacts (People to whom the student may be released in case of illness or injury when parent cannot be reached)**

Name _____ Relationship to Student _____

Home (_____)_____ Cell (_____)_____

Work (_____)_____ Pager (_____)_____

Name _____ Relationship to Student _____

Home (_____)_____ Cell (_____)_____

Work (_____)_____ Pager (_____)_____

**Other Contact** _____ Relationship to Student _____

Home (_____)_____ Cell (_____)_____

Work (_____)_____ Pager (_____)_____

Physician Name_____ Phone_____ Dentist Name_____ Phone_____

Medicaid/Waiver/Ins. Co. _____ Group # _____ Policy #_____

Hospital of Choice _____

**Health Information**: List any significant or on-going condition (i.e. severe allergies/EpiPen, asthma, A.D.D., birth defect, diabetes, epilepsy, heart disease, vision or hearing problem) or any condition relevant to school or athletics.

Explain _____

**MEDICATION** taken on a regular basis: **At School** _____ **At Home** _____

**Allergies to foods, medications, bee stings** (specify): _____

**MEDICAID INFORMATION**: Colorado school districts are entitled by law to seek Medicaid reimbursement when health services are delivered to Medicaid-eligible students. These funds must be used to create of expand health services to all children in the district. *School Medicaid reimbursement does not affect the family's other Medicaid benefits in any way.*
**CONSENT FOR MEDICAID BILLING**: I give consent and authorize the Boulder Valley School District to release to Colorado Health Care Policy and Financing (HCPF) information related to Medicaid-eligible services delivered to my child, if/when my child is enrolled in the Medicaid program. (Sign in the area provided at the bottom of this form if you do not wish to give consent).
**EMERGENCY INFORMATION**: Parents are expected to transport their own children from school to home or from school to doctor's office except in cases of dire emergency. In the event of an accident or acute illness, school staff shall attempt to notify the parents first. If neither the parent nor the emergency contacts can be reached, the school officials are hereby authorized to take whatever action, including the use of an ambulance, if deemed necessary in their judgment for the health and safety of the aforesaid student.
**CONSENT FOR EMERGENCY TREATMENT**: I, the undersigned, do hereby authorize officials of the Boulder Valley School District to contact directly the persons named on this card and do authorize the named physician or dentist to render such treatment as may be deemed necessary in an emergency for the health of the said student. In the event the named physician or dentist is not available at the time of the student's emergency, I hereby authorized the physician or dentist to whom the student is subsequently referred to render such treatment as may be necessary for the health of said student.
**I will not hold the Boulder Valley School District financially or legally responsible for the emergency care and/or transportation for such student**

**Parent/Guardian Signature**_____ **Date**_____

☐ I DO NOT wish to give consent for Medicaid billing. See above for explanation.

Parent/Guardian Signature_____ Date_____