EMERGENCY INFORMATION School Year: _________ **Student Name:** ____
Last First Nickname
Boulder Valley School District RE-2
School: ________________________ **Gender:** ☐ Male ☐ Female **Birth Date:** _________________ **Grade:** _______

		Home Phone	Work Phone	Cell Phone	Pager #
Parent/Guardian1	Parent/Guardian 1 Address: (Street & City/ Zip)				
Parent/Guardian 2	Parent/Guardian 2 Address: (Street & City/ Zip)				
Emergency Contact 1	Relationship to student:				
Emergency Contact 2	Relationship to student:				
Emergency Contact 3	Relationship to student:				
Emergency Contact 4	Relationship to student:				

Emergency Contacts are those people to whom the student may be released in case of illness or injury when parent cannot be reached.

Physician Name: _______________________ Phone: ____________Dentist Name: _________________________ Phone: _________________
Medicaid/ Waiver/ Insurance Co: ______________________________ Policy #: _________________
Preferred Hospital: ____
HEALTH INFORMATION: List any significant or ongoing condition (for example: severe allergies/ EpiPen, asthma, A.D.D./A.D.H.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 or 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. (See below 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 authorize 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: ____ Relationship: _______________________ Date: ____________

☐ I **DO NOT** wish to give consent for Medicaid billing. See above for explanation.
Parent / Guardian Signature: ____Relationship: _______________________ Date: ____________