

# Murrieta Valley USD

## Emergency-Release/Health Form

School Year \_\_\_\_\_

School \_\_\_\_\_

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle Name

\_\_\_\_\_  
Grade

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Sex

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, Zip

\_\_\_\_\_  
Student Cell Phone

\_\_\_\_\_  
Student Email Address

### Parent/Guardian Contact Information

Parent/guardian active duty military?  Yes  No

Student lives with:  Father  Mother  Step-Father  Step-Mother  Guardian/Other

\_\_\_\_\_  
Father's Full Name

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Father's Email Address

\_\_\_\_\_  
Mother's Full Name

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Mother's Email Address

\_\_\_\_\_  
Step-Father's Full Name

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Step-Mother's Full Name

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Email Address

### Additional Emergency/Release Contacts

\_\_\_\_\_  
Name

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Relationship

\*List those individuals to whom your child MAY NOT be released under LEGAL custody provisions. (Legal papers must be on file at school)

**Siblings (Names of all children in your family) if 18 yrs old, can they pick-up sibling?**  Yes  No

\_\_\_\_\_  
Name

\_\_\_\_\_  
Age

\_\_\_\_\_  
School

\_\_\_\_\_  
Name

\_\_\_\_\_  
Age

\_\_\_\_\_  
School

\_\_\_\_\_  
Name

\_\_\_\_\_  
Age

\_\_\_\_\_  
School

\_\_\_\_\_  
Name

\_\_\_\_\_  
Age

\_\_\_\_\_  
School

### Health History

Please check any health problems and/or medications your child requires at school or home. If medication is taken at school, written parent & physician authorization must be on file and renewed annually. Inhalers are allowed to be carried if student is able to demonstrate proper administration, safety and knowledge of medication and parent and physician permission and authorization are on file and renewed annually. **(PLEASE EXPLAIN ANY CONDITIONS BELOW)**

<input type="checkbox"/> ZAA - No Known Health Problems	<input type="checkbox"/> ZCB - Cardiac Problem - PE Restriction (Explain)	<input type="checkbox"/> ZHI - Hearing Impaired (Explain)
<input type="checkbox"/> ZAB - Anxiety/Emotional Disorder (Explain)	<input type="checkbox"/> ZCD - Cardiac Problem - No Restriction	<input type="checkbox"/> ZHM - Hemophilia - (Limitations?) (Explain)
<input type="checkbox"/> ZAD - Attention Deficit Disorder - Takes Meds	<input type="checkbox"/> ZCP - Cerebral Palsy	<input type="checkbox"/> ZKT - Kidney Disorder (Explain)
<input type="checkbox"/> ZAE - Attention Deficit Disorder - Takes No Meds	<input type="checkbox"/> ZCV - Color Blindness	<input type="checkbox"/> ZLX - Latex Allergy
<input type="checkbox"/> ZAI - Autism	<input type="checkbox"/> ZCF - Cystic Fibrosis	<input type="checkbox"/> ZMC - Menstrual Cramps (Meds @ School?) (Explain)
<input type="checkbox"/> ZAL - Allergies - Seasonal	<input type="checkbox"/> ZDD - Down Syndrome	<input type="checkbox"/> ZMH - Medication taken @ Home? (Explain)
<input type="checkbox"/> ZAR - Arthritis - (Limitations?) (Explain)	<input type="checkbox"/> ZDI - Diabetes - Type 1 - Insulin @ School (Explain)	<input type="checkbox"/> ZPE - PE Restriction (Needs Dr.'s note)
<input type="checkbox"/> ZAS - Asthma-mild - No meds at School	<input type="checkbox"/> ZDN - Diabetes - Type 2	<input type="checkbox"/> ZSB - Spina Bifida
<input type="checkbox"/> ZAT - Asthma-Carries Inhaler-Need Med Auth	<input type="checkbox"/> ZEA - Eating Disorder (Explain)	<input type="checkbox"/> ZSC - Scoliosis
<input type="checkbox"/> ZAU - Asthma-Inhaler-Kept in Health Office	<input type="checkbox"/> ZFA - Food Allergy (Explain)	<input type="checkbox"/> ZSE - Seizure Disorder/Epilepsy (Type/frequency)
<input type="checkbox"/> ZBB - Bee Sting Allergy - Has Epi-Pen	<input type="checkbox"/> ZGD - Genetic Disorder (Explain)	<input type="checkbox"/> ZTR - Tourettes Syndrome
<input type="checkbox"/> ZBE - Bee Sting Allergy - No meds at School	<input type="checkbox"/> ZGI - Gastrointestinal Problems (Explain)	<input type="checkbox"/> ZVI - Visually Impaired, Blind
<input type="checkbox"/> ZBL - Blood Disorder (Explain)	<input type="checkbox"/> ZGR - Growth Disorder (Explain)	<input type="checkbox"/> ZZZ - Other
<input type="checkbox"/> ZBP - High Blood Pressure (Restrictions?)	<input type="checkbox"/> ZHD - Previous Head Injury (When)	
<input type="checkbox"/> ZCA - Cancer/Leukemia (When?)	<input type="checkbox"/> ZHE - Headaches/Migraines (Medications?)	

Explanation: \_\_\_\_\_

Medication (types and doses): \_\_\_\_\_ Need to be taken at school? (Dr's Authorization required)  Yes  No

Health information is confidential and is shared with staff on a need to know basis. Please contact the school nurse if you have any questions.

Parent/Guardian Signature \_\_\_\_\_

\_\_\_\_\_  
Date

Signature of parent/guardian is required for emergency treatment, including emergency treatment of anaphylaxis, verification of health concerns and permission to share information with appropriate staff. Please notify the school of any changes to this document.