



LOS ANGELES UNIFIED SCHOOL DISTRICT STUDENT EMERGENCY INFORMATION FORM

Parent Information: Please fill out completely and sign where indicated. In a major emergency, it is school district policy to retain students at school for their safety. This form will be used by the school staff when students are released to go home. Please complete electronically or print clearly and return completed form to school.

STUDENT'S LAST NAME				FIRST NAME				M.I.		STUDENT'S LAST NAME	
BIRTH DATE		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		GRADE		HOME LANGUAGE					
STUDENT'S HOME ADDRESS -- NUMBER			STREET			APT #		CITY			ZIP CODE
MAILING ADDRESS -- NUMBER <small>(IF DIFFERENT FROM ABOVE)</small>			STREET			APT #		CITY			ZIP CODE
PARENT'S / LEGAL GUARDIAN'S LAST NAME			FIRST NAME			RELATIONSHIP TO STUDENT			LIVES WITH? <input type="checkbox"/> Yes <input type="checkbox"/> No		
WORK ADDRESS -- NUMBER		STREET				CITY			ZIP CODE		
CONTACT NUMBERS				Indicate which phone to call for each message type:*				EMAIL ADDRESS:			
HOME		EMERGENCY	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work						
CELL		ATTENDANCE	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work						
WORK		GENERAL INFO	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work						
TEXT		<input type="checkbox"/>	I authorize receiving text messages and understand that I am responsible for all text related charges.								
PARENT'S / LEGAL GUARDIAN'S LAST NAME			FIRST NAME			RELATIONSHIP TO STUDENT			LIVES WITH? <input type="checkbox"/> Yes <input type="checkbox"/> No		
WORK ADDRESS -- NUMBER		STREET				CITY			ZIP CODE		
CONTACT NUMBERS				Indicate which phone to call for each message type:*				EMAIL ADDRESS:			
HOME		EMERGENCY	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work						
CELL		ATTENDANCE	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work						
WORK		GENERAL INFO	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work						
TEXT		<input type="checkbox"/>	I authorize receiving text messages and understand that I am responsible for all text related charges.								
<i>To the principal: In case you are unable to reach me during any emergency, you are authorized to contact and, if necessary, release my child to any of the following:</i>											
NAME			RELATIONSHIP			HOME PHONE		CELL PHONE		WORK PHONE	
NAME			RELATIONSHIP			HOME PHONE		CELL PHONE		WORK PHONE	
NAME			RELATIONSHIP			HOME PHONE		CELL PHONE		WORK PHONE	
<i>List any other family members attending this school:</i>											
LAST NAME			FIRST NAME			HOME ROOM		GRADE		RELATIONSHIP	
LAST NAME			FIRST NAME			HOME ROOM		GRADE		RELATIONSHIP	
MILITARY CONNECTED FAMILY: In efforts to provide resources and support to military connected students and their families, please respond to the following:			Immediate family member in the military (Active Duty, Guard, Reserve, or Veteran): <input type="checkbox"/> YES <input type="checkbox"/> NO Relationship to Student: _____				Currently Deployed: <input type="checkbox"/> YES <input type="checkbox"/> NO Military Branch: _____ Status: <input type="checkbox"/> Active Duty; <input type="checkbox"/> Guard; <input type="checkbox"/> Reserve; <input type="checkbox"/> Veteran; <input type="checkbox"/> Deceased				
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT											
The undersigned, as parent/legal guardian of, _____ a minor, <small>(Print name of the student here)</small> hereby authorizes the principal or designee, into whose care the student has been entrusted, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to the student upon the advice of any licensed physician and/or dentist. It is understood that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the Los Angeles Unified School District ("District") to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary. This authorization is given in accordance with Section 49407 of the California Education Code, and shall remain effective until revoked in writing and delivered to the District. I understand that the District, its officers and its employees assume no liability of any nature in relation to the transportation of the student. I further understand that all costs of paramedic transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my sole responsibility as the student's parent/guardian.											
HEALTH ALERTS -- List any medical condition which restricts physical activity or requires special attention. Include conditions such as asthma and allergies such as peanut and bee stings. If none, please indicate "none".											
DOES THE STUDENT HAVE HEALTH INSURANCE? (Check One) <input type="checkbox"/> YES <input type="checkbox"/> NO* If "Yes": <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Healthy Families											
MEDI-CAL / HEALTHY FAMILIES ID Number:											
1. PRIVATE HEALTH INSURANCE NAME				GROUP NO.		2. PRIVATE HEALTH INSURANCE NAME <small>(If covered under more than one plan)</small>				GROUP NO.	
NAME OF DOCTOR / MEDICAL OFFICE						PHONE NUMBER OF DOCTOR / MEDICAL OFFICE					
<small>*If the student currently does not have health insurance, information on free or low-cost health care programs is available by calling the District's toll-free HELPLINE 1(866)742-2273.</small>											
MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICATIONS:											
MY CHILD CURRENTLY TAKES THE FOLLOWING MEDICATIONS:											
I CERTIFY THAT I HAVE READ AND UNDERSTOOD THIS FORM AND DO HEREBY GIVE MY AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT, AND THAT ALL OF THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE AND CORRECT.											
X SIGNATURE OF: _____ (CHECK ONE) <input type="checkbox"/> PARENT <input type="checkbox"/> LEGAL GUARDIAN <input type="checkbox"/> CAREGIVER (AFFIDAVIT)										DATE _____	

STUDENT'S LAST NAME

FIRST NAME

MIDDLE INITIAL

* Selected telephone number must be a direct dial number (no extensions).



STUDENT HOUSING QUESTIONNAIRE (SHQ)

The McKinney-Vento Homeless Assistance Act, part of Every Student Succeeds Act (ESSA), entitles all school-aged children experiencing homelessness access to the same free, appropriate public education that is provided to non-homeless youth. Schools are required to remove barriers to enrollment, attendance, and academic success of students experiencing homelessness. To determine eligibility please complete this form. For additional information, please contact the Homeless Education Office at (213) 202-7581.

Student First Name:		Student Last Name:		Date of Birth:	Gender:
Local District:	School:	Campus/Site:	Grade:	Student District ID:	
Address:		Apt#:	City:	Zip Code:	
Parent/Guardian Name:			Contact Number:		
Is the student: (check all that apply): <input type="checkbox"/> a parenting teen? <input type="checkbox"/> an unaccompanied youth? <input type="checkbox"/> a runaway?					
Has the student transferred schools any time after completing the second year of high school? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, forward a copy of SHQ to school's academic counselor for AB1806 eligibility.					



Is the student currently living in one of the Nighttime Residence options listed below?



YES NO

If you answered "NO" to this question, please STOP and sign below. If you answered "YES", complete the remainder of the form.

CHECK (✓) ONE OF THE NIGHTTIME RESIDENCE OPTIONS THAT BEST DESCRIBES YOUR CURRENT LIVING SITUATION DUE TO THE LOSS OF HOUSING:

Shelter (ex. Homeless, Domestic Violence...etc) Name:	Motel or Hotel Name:
Garage (unconverted)	Car, trailer, or campsite
Temporarily in another family's house or apartment	Temporarily with an adult that is not the parent or guardian
Transitional Housing Program Name:	Trailer/motor home on private property
Other places <u>NOT</u> designated for or ordinarily used as a regular sleeping accommodation for human beings Explain: _____	

Is the student in need of services? YES NO

If yes, please check the services being requested.

Backpack/School Supplies Hygiene Kits Transportation Assistance *

*If you are requesting transportation assistance, please read and sign the affidavit below:

I need assistance from LAUSD, as I have no alternate means to deliver my child to school. I agree to have my child attend school every day and on time. I also agree to notify the District if our situation changes or we no longer require this assistance. I understand that my child must meet the eligibility criteria for transportation assistance and I must comply with sign-in and supervision requirements.

If transportation is denied, the School-Site Homeless Liaison will be notified. Parent/Guardian can appeal.

Parent/Guardian's Initials: _____ Date: _____

Is the student in need of a referral for additional resource(s)? YES NO

If yes, please check the referral(s) being requested.

Clothing Assistance: Shoes, Clothing, Uniforms Tutoring Housing Referrals Assistance for a Parenting Teen

Designated School Site Homeless Liaison must conference with family to facilitate the requested referral(s)

Your Designated School Site Homeless Liaison is:

Name	Title	Phone	E-mail
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Do you have other preschool and/or school aged children in the home? YES NO

If yes, please complete an additional SHQ. All sibling(s) must have an SHQ on file at their school site.

AFFIDAVIT- By signing this form, I declare under penalty of the laws in the State of California that the foregoing is true and correct. In addition, I understand that the District reserves the right to verify the above listed residence information.

Signature of Parent/Legal Guardian/Caregiver: _____ Date: _____

SCHOOL PLEASE NOTE:

- ✓ Upon completion, please fax to (213) 580-6551 OR scan and email SHQ to your corresponding Local District: shqldc@lausd.net, shqlde@lausd.net, shqldne@lausd.net, shqldnw@lausd.net, shqlds@lausd.net, or shqldw@lausd.net
- ✓ SHQ MUST be kept in a CONFIDENTIAL file, which is separate from the permanent student record (this form must NOT be placed in the cumulative file).



**Los Angeles Unified School District
Parent/Guardian Publicity Authorization and Release**

Dear Parent/Guardian:

The Los Angeles Unified School District requests your permission to reproduce through printed, audio, visual, or electronic means activities in which your pupil has participated in his/her education program. Your authorization will enable us to use specially prepared materials to (1) train teachers and/or (2) increase public awareness and promote continuation and improvement of education programs through the use of mass media, displays, brochures, websites, social media, approved blogs, and related District publications.

1. Name of Pupil (please print)

2. Birthdate (please print)

3. Name of Parent (please print)

- a. I, as a parent or guardian, of the above named pupil fully authorize and grant the Los Angeles Unified School District and its authorized representatives, the right to print, photograph, record, and edit as desired, the biographical information, name, image, likeness, and/or voice of the above named pupil on audio, video, film, slide, or any other electronic and printed formats, currently developed, (known as "Recordings"), for the purposes stated or related to the above.
- b. I understand and agree that use of such Recordings will be without any compensation to the pupil or the pupil's parent or guardian.
- c. I understand and agree that the Los Angeles Unified School District and/or its authorized representatives shall have the exclusive right, title, and interest, including copyright, in the Recordings.
- d. I understand and agree that the Los Angeles Unified School District and/or its authorized representatives shall have the unlimited right to use the Recordings for any purposes stated or related to the above.
- e. I hereby release and hold harmless the Los Angeles Unified School District and its authorized representatives from any and all actions, claims, damages, costs, or expenses, including attorney's fees, brought by the pupil and/or parent or guardian which relate to or arise out of any use of these Recordings as specified above.

My signature shows that I have read and understand the release and I agree to accept its provisions.

4. Signature of Parent/Guardian

5. Date Signed

6. Address (Number, Street, Apartment Number)

7. City

8. State

9. Zip Code

10. Telephone

Granting of permission is voluntary. Please return completed form to school.

11. Principal

**Approved as to form by the
Office of the General Counsel.**

12. School

This form shall not be amended without written approval of both the Office of the General Counsel and the Office of Communications and Media Relations.