Caspar Creek Learning Community

Emergency Card / Contact Information

Student Name:	Gender:	Grade:	Birthdate:	Age:
Physical Address:	City:		State:	Zip:

Parent/Guardian 1

Name:	Relationship to Student:	Lives with Student?
Physical Address: *If different from student	City:	State: Zip:
Home Phone: Cell Phone:	Work Phone:	Email:

Parent/Guardian 2

Name:	Relationship to Student:	Lives with Student?
Physical Address: *If different from student	City:	State: Zip:
Home Phone: Cell Phone:	Work Phone:	Email:

Emergency Contacts
(Relatives/neighbors/friends who will assume temporary care of your child if you cannot be reached)

Contact 1 Name:	Relationship to student:	Phone Number 1:	Phone Number 2:
Contact 2 Name:	Relationship to student:	Phone Number 1:	Phone Number 2:

Other Children in Family

Name	Gender	Year Born	School Currently Attending	Over 18?	Relationship to student

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Health Information

Medications taken by student at school or at home (written authorization from doctor required for medication taken at school):

Other Health Condition:

What action is to be taken if student has a complication due to their allergic condition or other health condition (please be specific):

Known Conditions:

☐ Asthma
☐ Bee Sting Allergy
☐ Diabetes
☐ Epilepsy
☐ Other: _____

☐ Heart Condition
☐ Nut Allergy
☐ Seizures

Hearing
☐ Known hearing problems
☐ Wears heading aid

Vision
☐ Glasses to be worn at all times
☐ Known eye condition/defect in vision
☐ Wears contact lenses
☐ Wears glasses

Health Insurance Carrier:	Insurance ID or Policy #:	Hospital Preference:
Name of Primary Care Physician:	Address:	Phone:
Name of Ophthalmologist/Optometrist (Vision):	Address:	Phone:
Name of Audiologist (Hearing):	Address:	Phone:

In case of accident or other emergency, if parent/guardian cannot be reached, I hereby authorize a representative of the school to make such arrangements as they consider necessary for my child to receive medical or hospital care, including necessary transportation.

Under such circumstances, I further authorize the physician named above to undertake such acts and treatments of my child as they consider necessary. In the event said doctor is not available, I authorize such care and treatment to be performed by any licensed physician or surgeon.

I certify that all of the statements and information given above are true and correct to the best of my knowledge. I also agree to bear all costs incurred as a result of medical treatment or transportation required for such. This authorization will remain in effect until revoked by the undersigned in writing.

Parent/Guardian Signature: _____ Date: _____

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Release of Records

In accordance with the Family Educational Rights and Privacy Rights Act of 1974 and California State Law, please release to the school named below all records, including:

Cumulative Record
Transcripts of Completed Work Including Grades to Date
CELDT Scores and Related EL Information
Any Other Educational Information
Immunization Records
CSIS Student Number
IEP/504 Information

For Parent to Complete

Student Name: _____ Birthdate: _____ Grade: _____

Parent/Guardian Signature: _____ Date: _____

Name of Last School Attended: _____

Fax Number of Last School Attended Registrar Office (to request records): _____

Address of Last School Attended: _____
(Street Address, City, State, and Zip Code)

Dates Attended: _____ ☐ Student was not previously enrolled in school

Pivot Charter School Use

Please **FAX** the following records **(student has not officially started yet)**:

Transcript **Immunizations** **Withdrawal Grades** **Discipline Records** **Other:_____**

Please **MAIL** the cume file at your earliest convenience.

(Student is officially enrolled with a start date of: _____)

Receiving Registrar

Please complete the following in response to education records, sign and date, and return either by FAX or by MAIL.

Please check the appropriate box(es):

☐ Expulsion Dates: From _____ To _____

☐ Expulsion Pending ☐ E.C. #49079 Advise Teacher Regarding Violent Pupil

☐ IEP ☐ 504 ☐ Student is/has been recently suspended

REGISTRAR - PLEASE FORWARD THE STUDENT CUMULATIVE RECORDS TO:

Pivot Charter School - North Bay
2999 Cleveland Ave, Suite D
Santa Rosa, CA 95403
(P) 707-843-4676 (F) 707-544-2908 Email: atoso@pivotcharter.org