

EMERGENCY HEALTH INFORMATION

Student's Name _____ Birth Date _____ Grade _____

Home Address _____ Zip Code _____ Phone _____

Alternate Address _____ Zip Code _____ Phone _____

Day Phone # of Father/Guardian _____ Cell Phone/Pgr. _____ Name _____

Day Phone # of Mother/Guardian _____ Cell Phone/Pgr. _____ Name _____

Relative, friend or neighbor who has been authorized by parent to pick up child if parent cannot be reached:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Medical Insurance: Name _____ ID# _____

I understand that the school does not assume responsibility for payment of a physician in any case. However, in an emergency the school may choose a physician. Please state: Yes _____ No _____

Name of Doctor _____ Phone _____

Name of Dentist _____ Phone _____

Is your child allergic to any drugs? Yes ___ No ___ If yes, what? _____

Foods? Yes ___ No ___ If yes, what? _____

(Bee sting, etc.) Other? Yes ___ No ___ If yes, what? _____

Does your child have any chronic illness (asthma, diabetes, heart disease, epilepsy)?

If yes, what? _____

Does your child take any medicines on a regular basis? Yes _____ No _____

If yes, what and what for? List: _____

CONSENT FOR EMERGENCY TREATMENT

(I)(We), the undersigned parent(s) or legal guardians of _____, a minor, do hereby authorize a representative of _____ School as agent(s) for the undersigned consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care that is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the California Medicine Practice Act, on the medical staff of an accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of the above-mentioned agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care that the above-mentioned physician in the exercise of his or her best judgement may deem advisable.

This authorization shall remain effective until June 30, 20__ unless sooner revoked in writing and delivered to the above-mentioned agent(s).

Mother's signature _____ Date _____

Father's signature _____ Date _____

Legal Guardian's signature _____ Date _____

(Office Copy-White (MUST HAVE ORIGINAL SIGNATURES); Classroom Copy-Blue; Extended Care Copy-Yellow)