

## EMERGENCY HEALTH INFORMATION 2009-2010

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Grade \_\_\_\_\_  
Home Address \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_  
Alternate Address \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_  
Day Phone # of Father/Guardian \_\_\_\_\_ Name \_\_\_\_\_  
Day Phone # of Mother/Guardian \_\_\_\_\_ Name \_\_\_\_\_  
Mother's Cell Phone \_\_\_\_\_ Father's Cell Phone \_\_\_\_\_  
Mother's e-Mail \_\_\_\_\_ Father's e-Mail \_\_\_\_\_  
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 \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Out of area/state contact: Name/Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

### HEALTH INFORMATION

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? Yes \_\_\_ No \_\_\_ If yes, what? \_\_\_\_\_  
other? Yes \_\_\_ No \_\_\_ If yes, what? \_\_\_\_\_  
Does your child have any chronic illness (i.e. 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 All Saints Catholic School as agent(s) for the undersigned to 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 judgment may deem advisable.

This authorization shall remain effective until June 30, 2010, 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 \_\_\_\_\_