

EMERGENCY HEALTH INFORMATION 2008-2009

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 agents(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, 2007, 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 _____