STUDENT Emergency Information 2019-2020

First Name: ______________________ Last Name: _________________________________

Gender: ___ DOB:_____________ Grade: _____

Parent/Guardian #1: ____ email:______________________

Household #1 address: ____

CIty: ____ State: _____________ Zip: _________________

Home Phone: ___________________ Cell Phone: ___________________ Work Phone: _______________________

Parent/Guardian #2: ____ email:______________________

Household #2 address: ***(if different)***____

CIty: ____ State: _____________ Zip: _________________

Home Phone: ___________________ Cell Phone: ___________________ Work Phone: _______________________

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Custody agreement: Yes ______ No______ ***If yes, please provide a copy of the custody agreement.***

Medical Information

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 ______

Doctor: ____ Phone: __________________

Dentist:____ Phone: __________________

Medical Insurance Carrier: ____

Medical Insurance ID#: __________________________________ Medical Group #: ___________________________

Medical Alert: ____

____

Allergies(drugs, food,other):____

____

____

Other Medical Considerations/Chronic Illness: (asthma, diabetes, heart disease, epilepsy)

____

____

Does your child take any medication on a regular basis? If yes, list medication/reason.

____

____

Medication may only be administered/taken at school with a Care Plan signed by the Health Care Provider. A Permission to Self-Medicate for a life threatening condition must also be on file if the student will carry and self-medicate.

Emergency Contacts

My child may be released to one of these contacts in the event of illness, emergency, or disaster.

Contact #1: ____ Relationship: _____________

Phone Number: ____

Contact #2: ____ Relationship: _____________

Phone Number: ____

Contact #3____ Relationship: _____________

Phone Number: ____

Contact #4: ____ Relationship: _____________

Phone Number: ____

Contact #5: ____ Relationship: _____________

Phone Number: ____

Contact #6: ____ Relationship: _____________

Phone Number: ____

CONSENT FOR TREATMENT

I(We), the undersigned parent(s) or legal guardian of______________________________, a minor do hereby authorize a representative of St. Theresa 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, 20____, unless sooner revoked in writing and delivered to the above mentioned agent(s).

____

Parent /Guardian Signature Date

____

Parent/Guardian Signature Date

____

STUDENT RELEASE INFORMATION FOR SCHOOL USE ONLY **Date:**_____________ **Time:**_______________

____

Name of person student released to Relationship

Phone Number____

Destination____

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