ST. THERESA SCHOOL

Emergency Information
2013/14 SCHOOL YEAR

4850 Clarewood Drive, Oakland, CA 94618 | 510.547.3146 | www.sttheresaschool.org

PLEASE COMPLETE THIS FORM WITH BLACK INK

Student's Name | Date of Birth | Grade

Home Address

Home phone number

Mother's/Guardian's Name

Home phone number | Work phone number | Cell phone number

Email address

Father's/Guardian's Name

Home phone number | Work phone number | Cell phone number

Email address

Primary emergency contact person(s) who has been authorized by the parent to pick up the child if the parent cannot be reached:

1. Name & Relationship

Home phone number | Work phone number | Cell phone number

2. Name & Relationship

Home phone number | Work phone number | Cell phone number

Medical Insurance Name | ID number

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 number

Name of Dentist | Phone number

Is your child allergic to any drugs? ☐ Yes ☐ No If yes, What? _____

Is your child allergic to any food? ☐ Yes ☐ No If yes, What? _____

Please list anything else your child is allergic to and what precautions need to be taken:

Does your child have any chronic illness (asthma, diabetes, heart disease, epilepsy)? ☐ Yes ☐ No

If yes, What? _____

Does your child take any medication(s) on a regular basis? ☐ Yes ☐ No

If yes, please list the medication and the reason for the medication _____

Please supply 3 days of medications taken on a daily basis to the Red Counter in case of emergency.
No medications will be administered without a Physician's request and a care plan.

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).

Mother's Signature _____ Date _____

Father's Signature _____ Date _____

Legal Guardian's Signature _____ Date _____

If there are changes during the school year to any phone numbers or addresses, please remember to provide the new information to the school office.

Major Earthquake/Disaster/Emergency Release

Child's Last Name _____ **First** _____ Grade _____

In the event of a major disaster or earthquake my child my be released to the following person(s):

1. Name & Relationship _____

Home phone number _____ Work phone number _____ Cell phone number _____

2. Name & Relationship _____

Home phone number _____ Work phone number _____ Cell phone number _____

In the event that the listed person(s) cannot get to the school I give my permission to release my child to any St. Theresa parent.

☐ Yes ☐ No

Parent(s)/Legal Guardian's Signature _____

You may also attach a preferred list with this form.

STUDENT RELEASE INFORMATION FOR SCHOOL USE ONLY

Student's Name _____ has been released to:

Name & Relationship _____

Phone Number _____ Time/Date _____ Location/Destination _____

Notes _____