ST. THERESA SCHOOL

STUDENT Emergency Information 2017-2018

First Name: _____ **Last Name:** _____

Gender: ___ **DOB:**_____ **Grade:** _____

Parent/Guardian #1: _____ **email:**_____

Household #1 address: _____

Clty: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Parent/Guardian #2: _____ **email:**_____

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

Clty: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

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 completed and 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 self-medicate. **Please provide the office with a 3 day supply of medication taken on a daily basis, in the event of an emergency.**

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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).

_____

Mother's Signature Date

_____

Father's Signature Date

_____

Legal Guardian's Signature

STUDENT RELEASE INFORMATION FOR SCHOOL USE ONLY **Date:**_____ **Time:**_____

_____

Name of person student released to Relationship

Phone Number_____

Destination_____

_____