



STUDENT Emergency Information 2020-2021

First Name: _____ Last Name: _____

Grade: _____ Gender: _____ DOB: _____

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: _____

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-Medicare for a life threatening condition must also be on file if the student will self-medicate.



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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: _____

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

STUDENT RELEASE INFORMATION FOR SCHOOL USE ONLY

Date: _____ Time: _____

Name of person student released to Relationship

Phone Number

Destination