



## Emergency Information 2014-2015

Student First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

### 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 Date

### STUDENT RELEASE INFORMATION FOR SCHOOL USE ONLY

(Student Name) \_\_\_\_\_ has been released to:

(Name & Relationship) \_\_\_\_\_

Phone Number \_\_\_\_\_ Time/Date \_\_\_\_\_

Destination \_\_\_\_\_



## Emergency Information 2014-2015

Student 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: \_\_\_\_\_

Custody agreement: Yes \_\_\_ No \_\_\_

### 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 at school with a Care Plan completed and signed by the Health Care Provider. Medication may only be kept at the Red Counter.** Please provide the office with a 3 day supply of medication taken on a daily basis, in the event of an emergency.