

EMERGENCY CARD ~ 2011-2012

Day Care # _____

STUDENT'S NAME _____ **BIRTHDATE** _____ **GRADE** _____

Address _____ Phone _____

No. _____ Street _____ City _____ Zip _____

Name of Father (Living in home) _____ Employer's Name/City _____ Phone _____ Cell Phone _____

Name of Mother (Living in home) _____ Employer's Name/City _____ Phone _____ Cell Phone _____

If parents are divorced or separated, who has legal custody of the child? _____

Can other parent have contact with child? Yes No

Doctor's Name _____ City _____ Phone _____

Dentist's Name _____ City _____ Phone _____

In case of serious illness or accident, I hereby authorize school officials to call any local physician or paramedic if the above persons cannot be reached immediately.

Parent's Signature _____ **Date** _____

Persons with permission from legal custodian to whom the school may release the child due to illness, early pick up or Day Care pick up.

Name _____ Phone _____ Name _____ Phone _____

Name _____ Phone _____ Name _____ Phone _____

Name _____ Phone _____ Name _____ Phone _____

Relative outside California who may be called in a catastrophic emergency. Relationship to child: _____

Name _____ Address _____ City, State _____ Phone _____

AUTHORIZATION TO TREAT A MINOR

I (we) the undersigned parent, parents or legal guardian of (Student's Name) _____ a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the medicine practice act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California, Department of Public Health. 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 to render care which the aforementioned physician in the exercise of his best judgement may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

Insurance Company _____ Policy Number _____

Financial Responsibility _____ Last Tetanus Booster _____

Allergies to Drugs or Foods: _____

Special medications or pertinent information: _____

List any restrictions _____

Parent's Signature _____ Date _____

FIELD TRIP AUTHORIZATION

We give our permission for (Student's Name) _____ to accompany his/her class on all field trips throughout the current school year. Children will be accompanied by a teacher or staff member and will be under adequate supervision.

Parent's Signature _____ Date _____