SJES EMERGENCY HEALTH INFO FOR EXTENDED CARE

Student's Name _____ Birth date_____ Grade _____

Home Address _____ Zip Code _____ Phone_____

Alternate Address _____Zip Code_____ Phone_____

Day Phone # of Father/Guardian _____ CellPhone/Pgr _____ Name _____

Day Phone # of Mother/Guardian _____ CellPhone/Pgr _____ Name _____

Consent for Release

Relative, friend, or neighbor who has been authorized by parent to pick up child if parent cannot be reached:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Out of the area/state contact: Name/Relationship _____ Phone _____

Health Information

Medical Insurance: Name _____ ID#:_____

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 _____

Name of Dentist: _____ Phone _____

Name of Orthodontist: _____ Phone: _____

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

foods? Yes _____ No _____ If yes, what? _____

bee sting? Yes _____ No _____ If yes, what? _____

other? Yes _____ No _____ If yes, what? _____

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

If yes, what? _____

Does your child take any medications on a regular basis? Yes _____ No _____

If yes, what medication and what for? List: _____

Consent for Emergency Treatment

(I)(We), the undersigned parent(s) or legal guardian(s) of _____, a minor, do hereby authorize a representative of St. Joseph Elementary 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 06, 2014**, 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 _____

Copies of this form will be on file in the classroom, in the emergency evacuation binder, or where necessary.
If any of the above information changes, it is your responsibility to notify the school office in writing.