

EMERGENCY HEALTH INFORMATION

Student's Name Birth Date Grade
Home Address Home Phone
City Zip Code
Email Address (FOR NON-EMERGENCY USE ONLY!!)
Day Phone # of Father / Guardian Cell Phone Name
Day Phone # of Mother / Guardian Cell Phone Name

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

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I understand that the school does not assume responsibility for payment of a physician in any case. However, in an emergency the school may call 911 and my child may be transported to the nearest hospital with no cost to the school.

Yes No If no, how do you wish us to handle a serious emergency?

Name of Doctor Phone
Name of Dentist Phone

Is your child allergic to any Drugs? Yes No If yes, what?
Foods? Yes No If yes, what?
Other (Bee sting, etc)? Yes No If yes, what?

Does your child have any chronic illness (asthma, diabetes, heart disease, epilepsy)? Yes No
If yes, what?

Does your child take any medicines on a regular basis? Yes No
If yes, what and what for? List:

CONSENT FOR EMERGENCY TREATMENT

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

**St. Edward School
5788 Thornton Avenue
Newark, CA 94560**

EARTHQUAKE EMERGENCY DISMISSAL CARD

Student's Name Birth Date Grade
Home Address Home Phone
City Zip Code
Email Address (FOR NON-EMERGENCY USE ONLY!!)
Work Phone # of Father Cell Phone Name
Work Phone # of Mother Cell Phone Name

PLEASE LIST BELOW THE NAMES OF ALL THOSE TO WHOM YOU GIVE PERMISSION FOR ST. EDWARD SCHOOL AUTHORIZED PERSONNEL TO DISMISS YOUR CHILD TO:

NAME RELATIONSHIP TO CHILD

I UNDERSTAND THAT IF ST. EDWARD SCHOOL AUTHORITIES FEEL IT IS NECESSARY FOR MY CHILD TO RECEIVE EMERGENCY MEDICAL TREATMENT (PARAMEDICS, ETC.) THEY WILL ACT ACCORDINGLY.

If the child does not reside with both parents, may either parent take the child home from school? Yes No
If No, a certified court order MUST be in the child's records in the school office.

Mother's signature Date
Father's signature Date
Legal Guardian's signature Date

OUT OF STATE CONTACT:

Name Phone Relationship to child

Comments: