Emergency Health & RELEASE Form

Please Print Clearly

Student's Name _____ Birth Date_____ Grade_____

Home Address_____City_____Zip_____

Parent Email_____ Parent Email _____

Home Phone_____ CONTACT 1st: _____

Father/Guardian_____ Phone #_____

Mother/Guardian_____ Phone #_____

Relative/Friend/Neighbor who has been authorized to pick up child if parent cannot be reached:
Name_____ Relationship_____Phone_____
Name_____ Relationship_____Phone_____
Name_____ Relationship_____Phone_____
Medical Insurance: _____ 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_____

Is your child allergic to any Drugs? ☐ Yes ☐ No If yes, what?_____
Foods? ☐ Yes ☐ No If yes, what foods?_____
(Bee sting, etc.) Other? ☐ Yes ☐ No If yes, what?_____
Does your child have any chronic illness (asthma, diabetes, heart disease, epilepsy)?
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 guardians of , _____a minor, do hereby authorize a representative of St. Patrick School as agents(s) for the undersigned 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, 2018 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_____