Indian Diggings

EMERGENCY INFORMATION Teacher _____ BusInfo: _____

SS# _____ Student's Name _____
(Last) (First) (MI)

_____
Student's Home Address Student's Mailing Address, if different

How to find house _____

Brothers/Sisters _____ Date of Birth ___/___/___ Place of Birth _____

Father/Guardian _____
Name Home Address Phone

_____
Employer's Name Business Address Phone

Mother/Guardian _____
Name Home Address Phone

_____
Employer's Name Business Address Phone

Family physician _____
Name Phone

In case of emergency, illness or accident to the child in our absence, the school is authorized to proceed as follows:

_____

Persons who are to be called and/or a student may be released to if parent is not available. Include sitter information if applicable. Child may be released only to persons listed. In the event no one listed is available, school will make appropriate decision.

IT IS PARENT'S RESPONSIBILITY TO KEEP SCHOOL INFORMED OF ANY AND ALL CHANGES TO THE INFORMATION ON THIS EMERGENCY CARD.

_____ Name Phone

_____ Name Phone

_____ Name Phone

_____ Name Phone

School last attended _____

Authorization to Consent to Emergency Treatment of a Minor

(I) (We) the undersigned parent(s) of _____, a minor, do hereby authorize the _____ School District, as agents for the undersigned in our absence, to consent to X-ray examination, anesthetic, medical or surgical diagnosis or treatment and/or hospital care which is deemed advisable by, and is to be rendered, under the general or special supervision and upon the advice of any physician or surgeon licensed under the Medicine Act, whether such diagnosis or treatment is rendered at the office of said physician or at any duly licensed medical facility.

It is understood this authorization is given in advance of any specific diagnosis, treatment or hospital care required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent in any medical emergency to any and all such diagnosis, may deem advisable. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

A Photocopy of this Form is as Valid as the Original

The authorization shall remain in effect until revoked in writing and delivered to said agent(s).

Father _____ _____
Signature Date

Mother _____ _____
Signature Date

Pertinent Medical Details Regarding Above Minor Are:

Allergic Reactions: Yes ____ No ____ If yes, type of allergy(s): _____
Asthma: Yes ____ No ____ If yes, medication taken, if any: _____
Diabetes: Yes ____ No ____ Tetanus (date of last immunization): _____
Convulsions: Yes ____ No ____ If yes, type: _____
Medication Taken Regularly: Yes ____ No ____ If yes, name(s) of medication(s): _____
Other: _____ Time of day taken: _____
Insurance Company: _____ Policy Number: _____