EMERGENCY, HEALTH, AND DISMISSAL INFORMATION

STUDENT NAME _____ SCHOOL GRADE _____

MOTHER NAME _____ PHONE _____

FATHER NAME _____ PHONE _____

PERSONS TO WHOM YOU GIVE ST. EDWARD PERSONNEL PERMISSION TO DISMISS YOUR CHILD IN THE EVENT OF AN EMERGENCY:

NAME	RELATIONSHIP TO CHILD	PHONE
NAME	RELATIONSHIP TO CHILD	PHONE
NAME	RELATIONSHIP TO CHILD	PHONE

WHAT ALLERGIES DOES THIS CHILD HAVE? _____

CHRONIC ILLNESSES (i.e., asthma, diabetes, heart disease, epilepsy, etc)? _____

_____

PLEASE LIST ANY AND ALL REGULAR MEDICATIONS AND WHAT EACH MEDICATION IS FOR:

_____

_____

_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

CONSENT FOR TREATMENT

I understand that if St. Edward Faith Formation (SEFF) authorities feel it is necessary for my child to receive medical treatment (paramedics, ambulance, etc.), they will act accordingly. I understand that SEFF does not assume responsibility for payment of a physician.

(We) the undersigned parent(s) or legal guardian of this minor child, do hereby authorize a representative of the SEFF 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 and 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 the end of the current school year, unless revoked sooner in writing and delivered to the above-mentioned agent(s).

PARENT SIGNATURE _____ DATE _____/_____/_____

EMERGENCIA, MEDICA, Y ENTREGE

NOMBRE DEL ESTUDIANTE _____ GRADO ESCOLAR _____

NOMBRE DE LA MADRE _____ TELEFONO _____

NOMBRE DEL PADRE _____ TELEFONO _____

PERSONAS QUE USTED DA PERMISO QUE SE LE ENTREGE A SU HIJO/A EN CASO DE EMERGENCIA SI NO PODEMOS ENCONTRAR A LA MADRE O AL PADRE:

_____

NOMBRE RELACION CON EL ESTUDIANTE # DE TELEFONO

_____

NOMBRE RELACION CON EL ESTUDIANTE # DE TELEFONO

_____

NOMBRE RELACION CON EL ESTUDIANTE # DE TELEFONO

¿TIENE ALERGIAS?

_____

¿ENFERMEDADES CRONICAS (como el asma, diabetes, enfermedades del corazón, epilepsia, etc.)?

_____

MEDICINAS QUE ESTE TOMANDO EL ESTUDIANTE REGULARMENTE:

_____

_____

_____

POR FAVOR LLENEN LOS DOS LADOS DE LA FORMA

EMERGENCIA, MEDICA, Y ENTREGE

CONSENTIMIENTO PARA TRATAMIENTO MEDICO

Yo entiendo que si las personas de San Eduardo creen necesario que mi niño reciba tratamiento medico de emergencia (paramédicos, ambulancia, etc.) ellos tomaran las medidas necesarias.

Yo entiendo que las personas de San Eduardo NO asumen responsabilidades para pagos de Doctores en cualquier caso. En caso de una emergencia las personas de San Eduardo podrían escoger un doctor.

Yo (nosotros) papas de este menor, autorizamos a un representante del Departamento de Educación Religiosa de San Eduardo que tome decisiones de cualquier exanimación de rayos-x, anestesia, diagnosis o tratamiento y cuidado de hospital esta autorización es dada antes de cualquier diagnosis, tratamiento o cuidado de hospital

Esta autorización será efectiva hasta el fin del año corriente escolar, o ya que sea revocado per escrito.

FIRMA DE PADRE/MADRE _____ FECHA _____/_____/_____

POR FAVOR LLENEN LOS DOS LADOS DE LA FORMA