

# Creekside PTO

## Student Emergency Information

Student Name: \_\_\_\_\_

M - Male F - Female Birthplace: \_\_\_\_\_

School Use Only # \_\_\_\_\_ Grade \_\_\_\_\_

Enter Date \_\_\_\_\_

Leave Date \_\_\_\_\_

physical address \_\_\_\_\_

birth date \_\_\_\_\_

mailing address \_\_\_\_\_

home telephone \_\_\_\_\_

Father - Step Father - Guardian (circle one)

Mother - Step Mother - Guardian (circle one)

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Work Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email address \_\_\_\_\_

Email address \_\_\_\_\_

**PLEASE READ: California Ed Code 49406 indicates that for the protection of a pupil's health and welfare, the governing board of a school may require the parents or legal guardian to provide current emergency information, including the home address, business address and telephone numbers of the parents or guardians. In the event the parent or legal guardian cannot be reached, the name and telephone number of a relative or friend who is authorized to care for the pupil in an emergency situation is also required.**

If my child is ill, has an emergency, or is suspended and I cannot be reached, please release my child to:

Name \_\_\_\_\_ Phone \_\_\_\_\_ City \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ City \_\_\_\_\_

## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

As legal custodian of \_\_\_\_\_, a minor, I hereby authorize the Director or his/her designee, into whose care the aforementioned minor pupil has been entrusted, to initiate paramedic/ambulance care or transport for said minor and to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis, treatment and/or hospital care to be rendered to said minor upon the advice of any licensed physician and/or dentist.

I understand that this authorization is given in advance of any required diagnosis, treatment or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, and/or hospital care which a licensed physician or dentist may deem necessary.

This authorization shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand that Creekside Charter Management *and Creekside PTO, and staff* assume no liability of any nature in relation to the transportation or treatment of said minor. I further understand that all cost of paramedic/ambulance transportation, hospitalization and any examination, X-ray or treatment provided in relation to this authorization shall be my responsibility, and that Creekside Charter Management Schools do not provide medical insurance for student injuries.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

Or \_\_\_\_\_ I do not choose the above statement and desire the following action in the event of an emergency:

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

Family Doctor \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

Health Plan/Insurance Name and Number \_\_\_\_\_

My child has the following allergies \_\_\_\_\_

My child uses the following medications \_\_\_\_\_

My child has the following health problems \_\_\_\_\_