EMERGENCY INFORMATION CARD

Complete And Return This Card IMMEDIATELY. This Card is Vital CONSENT FOR TREATMENT

Your child may be unconscious when medical and personal information is needed.

(l), (We), the undersigned parent(s) or legae guardians _____ of a minor, do hereby authorize a representative of Sacred Heart School as agent for the undersigned to consent to any X-ray examinations, 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 abovementioned agent 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 judgement may deem advisable

This authorization is given pursuant to the provisions of Section 25.8 of the California Code of Civil Procedure. This authorization shall remain effective until _____, 20____ unless sooner revoked in writing and delivered to the above-mentioned agent.

Mother's Signature _____ Date _____

Father's Signature _____Date _____

Legal Guardian 's Signature _____Date _____

_____

Name of Student Grade

_____ _____

Student's Date of Birth _____Height _____Weight _____

Address _____Zip _____

Phone _____Email _____

In case of emergency illness or accident to the above student, the school is authorized to proceed as indicated:

1. Call student's mother, father, or legal guardian.

_____

Mother's/Legal Guardian 's Name

Mother 's/Guardian 's Daytime Phone _____ Mother's/Guardian's Cell Phone _____

Father 's/Legal Guardian's Name Father's/Guardian 's Daytime Phone

Father's/Guardian's Cell Phone

2. Call Physician

_____ _____ _____

_____ _____

Physician's Name Daytime Phone

3. If unable to contact student's mother, father, or legal guardian, call this relative, friend, or neighbor.

_____ _____

Name Daytime Phone

MEDICAL HISTORY

Please answer all questions, Comment on all affirmative responses in the space provided below.

Has Your Child Had?	Ye	N	Has Your Child Had?	Ye	No

Scarlet Fever			Aller to an of followin		
Measles			Penicillin		
German Measles			Sulfanilamides		
Mumps			Serum		
Chicken Pox			Foods (List Below)		
Malaria			Other		
Gum or Tooth Trouble			Palpitations (Heart)		
Sinusitis			High/Low Blood Pressure		
Eye Trouble			Rheumatic Fever		
Ear, Nose, Throat Troubl			'Trick" Knee or Shoulder		
SURGERY:			Heart Murmur		
Appendectomy			Back Problems		
Tonsillectom			Tumor, Cancer, C st		
Hemia Re air			Stomach, Intestinal Trouble		
Other			Gallbladder Trouble		
Epileptic Seizures			Rupture, Hernia		
Recurrent Colds			Dizziness, Fainting		
Head Injury - Unconciousness			Weakness, Paralysis		
Hay Fever			Frequent Urination		
Asthma			Diabetes		
Tuberculosis			Disease/lnjury of Joints		
Chronic Cough			Irregular Periods (Females)		

Please list here any medications taken by your son/daughter:

_____

_____

_____

Comments :

_____

_____

Have any instructions conceming your child's schoool activities been made by your physician? NO / Yes
If so, please explain:

_____

_____