

**ST. MARTIN-IN-THE-FIELDS SCHOOL
STUDENT EMERGENCY INFORMATION 2011 - 2012**

Student's Name _____ Birthdate _____
 Address _____ Home Phone _____
 City _____ Zip Code _____

Mother's Name _____ Work Phone _____
 Email address _____ Cell Phone _____
 Father's Name _____ Work Phone _____
 Email address _____ Cell Phone _____

In case of emergency and we cannot reach either parent, whom shall we notify?
 Name _____ Relationship to Child _____ Phone _____
 Child's Physician _____ Phone _____
 Insurance Company _____ Policy Number _____

Check those which apply:
 Wears Glasses Wears Contacts Has asthma
 Has serious hearing impairment
 Has unusual blood type; specify _____
 Has food, medicine or other allergies; specify _____

 Is under medication; specify _____

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

I/We the undersigned, parent(s)/guardian(s) of _____, a minor, do hereby authorize St. Martin's Episcopal School as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is rendered under the general or specific supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any 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 our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care deemed advisable. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective from September 1, 2011 to August 31, 2012 unless sooner revoked in a signed letter delivered to the school.

Date _____ Signature(s) of Parent(s) or Guardian(s):

Please note: St. Martin's School will render simple first aid to your child, as needed, unless instructed not to do so (in writing) by parents. For cuts and/or abrasions Neosporin and/or hydrogen peroxide will be used.

**ST. MARTIN-IN-THE-FIELDS EPISCOPAL SCHOOL
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DAILY OR EMERGENCY RELEASE

Student's Name _____

PERSONS AUTHORIZED TO PICK UP MY CHILD ON A DAILY BASIS OR IN AN EMERGENCY

	<u>NAME</u>	<u>HOME PHONE</u>	<u>WORK PHONE</u>	<u>RELATIONSHIP</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

SIBLINGS ATTENDING ST. MARTIN'S:

	<u>NAME</u>	<u>TEACHER</u>
1.	_____	_____
2.	_____	_____

In the event that a major earthquake or other disaster occurs while my child is at St. Martin's School, I give permission for my child to be released to the above person(s). I understand that my child will be cared for to the best of the School's ability at the time of the disaster. I also understand that such care will continue until a designated person arrives, and that the School will only release my child to myself or one of the persons designated above, unless the "Special Permission" box below is checked.

In case of an injury, I understand my child will be given the best medical attention available. I hereby release St. Martin's School, its employees, and designated supervisors from any liability which may result from the execution of any emergency procedure.

SPECIAL PERMISSION: Release my child to anyone who presents adequate evidence of relationship, and with whom my child appears to be comfortable.

Date _____

Signature(s) of Parent(s) or Guardian(s)

Out of State contact (optional):

Name _____ Relationship to child _____ Phone _____

Office use only:

Released to (print name) _____ Signature _____

Time _____ Date _____ Supervisor _____