Division of Alternative Education

EMERGENCY DATA AND TREATMENT AUTHORIZATION

PARENT OR LEGAL GUARDIAN TO COMPLETE ALL ITEMS, SIGN, AND RETURN FORM TO SCHOOL

NAME OF PUPIL (LAST NAME, FIRST NAME, MIDDLE NAME)	MALE ☐ FEMALE ☐	TELEPHONE # ( )	STUDENT CELL PHONE# ( )
COMPLETE ADDRESS (STREET, CITY, ZIP)	STUDENT EMAIL ADDRESS	FOSTER HOME YES ☐ NO ☐	

DISTRICT OF RESIDENCE	LANGUAGE SPOKEN AT HOME	BIRTH DATE	AGE	BIRTHPLACE

PARENT(S) LEGAL GUARDIAN RESPONSIBLE FOR PUPIL	BUSINESS ADDRESS OR HOME ADDRESS IF OTHER THAN ABOVE	BUSINESS PHONE #/ BUSINESS HOURS	CELL PHONE #/ EMAIL ADDRESS
FATHER	----------	( ) HRS:	( ) E:
MOTHER	----------	( ) HRS:	( ) E:
OTHER (SPECIFY RELATIONSHIP)	----------	( ) HRS:	( ) E:

If above person(s) cannot be reached, and child becomes ill or injured at school, list three alternative persons to act for parents. (They MUST have a telephone, be able to arrange for transportation, be known to child, and willing and able to act for parent(s) or legal guardian.)

NAME	ADDRESS	TELEPHONE NUMBER	RELATIONSHIP
1.	----------	( )	
2.	----------	( )	
3.	----------	( )	

SOCIAL SERVICE AGENCY (NAME, ADDRESS, TELEPHONE NUMBER) IF APPLICABLE

LIST CONDITIONS WHICH MIGHT LEAD TO SEIZURES, ASTHMA, LIST OTHER HEALTH PROBLEMS (CARDIAC, DIABETES, ETC) ALLERGIES (BEE STING, PENCILLIN, ETC)

NAME OF PHYSICIAN	OFFICE LOCATION	TELEPHONE NUMBER ( )
NAME OF DENTIST	OFFICE LOCATION	TELEPHONE NUMBER ( )

Responsible Party

Insurance Company	Policy and or Medi-Cal #

☐ My child wears the following type(s) of emergency identification: ☐None ☐Bracelet ☐Necklace ☐Other (specify) _____

LIST ANY RESTICTIONS and MEDICATIONS TAKEN:

SIGNATURE OF PARENT, LEGAL GUARDIAN, OR CAREGIVER DATE SIGNED

AUTHORIZATION FOR EMERGENCY TREATMENT OF A MINOR

In case of sudden illness or injury to your son/daughter, every effort will be made by school officials to contact you, your family physician, or the person named by you to be called in an emergency. If it os impossible to reach you, your signature above will assure emergency treatment by authorized medical and/or hospital personnel.

I (We), the undersigned parent(s)/(legal guardian) of the above named minor,do hereby authorize the Orange County Department of Education and its employees as agents 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 to be rendered under the general or specific supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital no matter where such service is rendered.

The agent for the undersigned and its employees are released of any civil or financial liabilities for the aforementioned diagnosis, treatment, hospital care, or any other acts performed that reasonable and necessary for the welfare of the minor.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization shall remain effective unless revoked in writing and delivered to said agent(s).

Distribution: WHITE - School Records CANARY - Parent/Legal Guardian, or Caregiver