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.

(I), (We), the undersigned parent/s or legal guardian of _____, a minor, do hereby authorize a representative of St. Bernard's Parish 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 but 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 caret that the above-mentioned physician in the exercise of his or her best judgment 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 June 2017, unless sooner revoked in writing and delivered to the above-mentioned agent/s.

Mother/Father/Legal Guardian's Signature _____ Date _____

Name of Student _____ Grade _____

Student's Date of Birth _____ Height _____ Weight _____

Address _____ Zip_____ Phone_____

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/Father/ Legal Guardian's Name_____ Daytime Phone _____

2. Call Physician.

Physician's Name _____ Daytime Phone _____

3. If unable to contact student's parents, call this relative, friend or neighbor.

Name _____Daytime Phone _____

MEDICAL HIISTORY

Please answer all questions. Comment on all affirmative responses in the space provided below. Circle Yes or No.

Has Your Child Had?		
Scarlet Fever	Yes	No
Measles	Yes	No
German Measles	Yes	No
Mumps	Yes	No
Chicken Pox	Yes	No
Malaria	Yes	No
Gum or Tooth Trouble	Yes	No
Sinusitis	Yes	No
Eye Trouble	Yes	No
Ear, Nose, Throat Trouble	Yes	No
SURGERY:		
Appendectomy	Yes	No
Tonsillectomy	Yes	No
Hernia Repair	Yes	No
Other:		
Epileptic Seizures	Yes	No
Recurrent Colds	Yes	No
Head Injury-Unconsciousness	Yes	No
Hey Fever	Yes	No
Asthma	Yes	No
Tuberculosis	Yes	No
Chronic Cough	Yes	No

Has Your Child Had?		
Allergy to any of following		
Penicillin	Yes	No
Sulfanilamide	Yes	No
Serum	Yes	No
Foods (List Below)	Yes	No
Other		
Palpitations (Heart)	Yes	No
High/Low Blood Pressure	Yes	No
Rheumatic Fever	Yes	No
Heart Murmur	Yes	No
Disease / Injury of Joints	Yes	No
"Trick" Knee or Shoulder	Yes	No
Back Problems	Yes	No
Tumor, Cancer, Cyst	Yes	No
Stomach, Intestinal Trouble	Yes	No
Gallbladder Trouble	Yes	No
Rupture, Hernia	Yes	No
Dizziness, Fainting	Yes	No
Weakness, Paralysis	Yes	No
Frequent Urination	Yes	No
Diabetes	Yes	No
Irregular Periods (Females)	Yes	No

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

Have any special instructions concerning your child's school activities been made by your physician? **Yes** **No** If yes, please explain:

_____