St. Francis Solano School: 2018 Summer Camp Emergency Information

Child's Last Name ______________________________ First __________________ Middle _______________

Grade________ Date of Birth _________________ Resides with (circle) Mother Father

Family's Primary E-Mail __________________________________ **Student's Cell #**______________________

Father/Guardian	**Mother**/Guardian
Call priority (circle one) 1 2 3	Call priority (circle one) 1 2 3
Name ______________________________________	Name ______________________________________
Mailing Address ____________________________	Mailing Address ____________________________
City ________________ State ______ Zip________	City ________________ State______Zip _________
H # ___________________ Cell _______________	H # _________________ Cell ________________
E-Mail ___________________ Self-Employed Y/N	E-Mail _________________ Self-Employed Y/N
Place of Employment ________________________	Place of Employment ________________________
Type of Work (specify) _____________________	Type of Work (specify) _____________________
W # ___________________ Work Hrs ___________	W # _________________ Work Hrs ____________

In case of emergency, illness or accident to the child named above, St. Francis Solano School is authorized to contact the following person. Every attempt will be made to notify parents first.

Name_________________________ Relationship________________ Phone_____________________________

Authorization to Consent to Treatment of Minor

In the event of serious emergency, and none of the above named persons can be contacted, I authorize school officials to call my family doctor, or if the situation demands, to transfer my child to the nearest hospital for the necessary emergency care. Parents will be responsible for ambulance charges. I 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 special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of a certified hospital, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital. This authorization is given pursuant to the provisions of Section 28.5 of the Civil Code of California.

I understand that the school does not assume responsibility for payment of a physician and/or ambulance. ____Yes ___ No

Name of Physician ____Phone ____________________

Address ____

Name of Dentist ____Phone ____________________

Address ____

HEALTH INFORMATION

Describe any allergies, including allergies to medication, health conditions and current medications or treatment.

Medical Condition/Allergies	**Treatment/Medication**
Allergies to Medications	**Treatment/Medication**

________________________________ ____________________________________ Date _____________

Signature Mother/Guardian Signature Father/Guardian