St. Francis Solano School: 2019 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

Call priority (circle one) 1 2 3

Name _____

Mailing Address _____

City _____ State _____ Zip_____

H # _____ Cell _____

E-Mail _____ Self-Employed Y/N

Place of Employment _____

Type of Work (specify) _____

W # _____ Work Hrs _____

Mother/Guardian

Call priority (circle one) 1 2 3

Name_____

Mailing Address _____

City _____State_____Zip _____

H # _____ Cell _____

E-Mail _____ Self-Employed Y/N

Place of Employment _____

Type of Work (specify) _____

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