

Garces Memorial High School Emergency Card

PERSONAL INFORMATION (please print):

Student's Name: _____ Grade Level in Fall of 2019: _____

*Student lives with: Mom & Dad Mom Dad Other _____

Parent/Guardian #1 Information

Full Name:

First _____ Middle _____ Last _____

Home Address:

Street _____

City _____ State _____ Zip _____

Mailing Address:

Street _____

City _____ State _____ Zip _____

Email Address: _____

Home: (____) _____ - _____

Work: (____) _____ - _____

Cell: (____) _____ - _____

Parent/Guardian #2 Information

Full Name:

First _____ Middle _____ Last _____

Home Address:

Street _____

City _____ State _____ Zip _____

Mailing Address:

Street _____

City _____ State _____ Zip _____

Email Address: _____

Home: (____) _____ - _____

Work: (____) _____ - _____

Cell: (____) _____ - _____

EMERGENCY INFORMATION

Emergency Contacts (OTHER THAN PARENT/GUARDIANS):

1) _____
Name Relationship (Area Code) Phone Number

2) _____
Name Relationship (Area Code) Phone Number

PLEASE CHECK ALL THE FOLLOWING THAT MAY APPLY:

- My son/daughter has permission to drive him/herself home in an emergency.
- Upon permission from the parents of his/her passengers, my son/daughter may drive his/her carpool home in case of an emergency.
- My son/daughter may only be released to either parent.
- My son/daughter may take the bus home, if available, in an emergency.
- My son/daughter may walk home in an emergency.

My son/daughter may be released to the following adults and/or carpool drivers (please print):

1) _____ 3) _____
2) _____ 4) _____

In case of an earthquake or natural disaster, school phone lines MUST be kept open. Please DO NOT call the school under any circumstances. If the need arises, we will contact you.

We, the parents/guardians, agree that in the event of emergency circumstances the administration of Garces Memorial High School may act in an appropriate manner to ensure our sons'/daughters' safety and well-being.

Parent/Guardian Signature _____

Parent/Guardian Signature _____

MEDICAL INFORMATION (please print):

Allergies: _____

Medical Conditions: _____

Medications: _____

Name of Primary Physician: _____ **Phone:** _____

Authorization to Consent to Treatment of a Minor

(I) (We), the undersigned, parent(s) of _____ a minor, do hereby authorize an administrator of Garces Memorial High 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 to be rendered under the general or GARCES supervision of any physician and 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 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 which the aforementioned physician in the exercise of his best judgment may deem advisable.

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

This authorization shall remain effective through June 2020.

Parent/Guardian Signature

Date

I, the undersigned, hereby request a designated school personnel of Garces Memorial High School, to assist in the matters stated on this form. I assure the school that my child may safely take the non-prescription medication described on this form, and I accept all consequences as a result of my child taking this medication. I understand that the school reserves the right to discontinue assistance to the child in the child's taking of non-prescribed medication at school. I accept the fact that school personnel who assist my child are not likely to have had medical training. I understand that in case of an error or adverse reaction to medication, the school resources are limited to calling emergency services (911) and the parent or guardian.

I release and discharge the school from any and all claims for liability or responsibility for death, illness, adverse reactions, personal injury, or property damage that my child or I may suffer as a result of this arrangement, whether or not such injuries or damage are caused by negligence (either active or passive) of the school. This waiver of all claims and release of the school also releases the Diocese of Fresno Education Corporation, the Roman Catholic Bishop of Fresno (a corporate sole), the Diocese of Fresno, all the Diocese of Fresno schools, all parishes, all affiliated organizations, and all of their officers, clergy, agents, and employees.

Name of non-prescribed medication: (**Generics** may be used in place of name brand)

Please check one or both

Advil

Tylenol

Signature of Parent or Guardian _____

Date _____

This form must be completed and returned to the school before any non-prescribed medication may be taken at school. Forms for over the counter medication are available at the Attendance office desk. This request will be effective for one school year only and will be maintained in your child's medical file.