Salesian College Preparatory

Emergency Medical Information

Student Name _____Grade _____Date of Birth_____
Parent(s)/Guardian(s):_____Home Phone_____
Cell Phone: (Mother/ Guardian) _____ (Father/Guardian)_____
Work Phone: (Mother/Guardian)_____ (Mother/Guardian)_____

Emergency Contact **other** than parent or guardian:
Name: _____ Home: _____Cell: _____Work: _____

Name of Insurance Company_____

List any special conditions such as allergies, illnesses, medications or pertinent medical history.

_____

_____

List any medications the student is currently taking.

_____

_____

I, the undersigned, as parent/legal guardian of the named student, a minor, do hereby authorize a representative of Salesian College Preparatory as agent for the undersigned to consent to any medical or surgical diagnosis or treatment and hospital care 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 Salesian College Preparatory to give specific consent to any and all such diagnosis, treatment or hospital care that the above mentioned physician in the exercise of his or her best judgment may deem advisable.

Parent/Guardian Signature: _____

Date: _____