

BISHOP MONTGOMERY HIGH SCHOOL EMERGENCY INFORMATION

EFFECTIVE June 2019 - June 2020

PLEASE PRINT

ACCURATE INFORMATION IS ESSENTIAL FOR THE SAFETY OF YOUR CHILD.

STUDENT INFORMATION

Student's Name: _____
Last First Middle Initial

Address: _____ City _____ Zip _____

Sex: M F (Circle one) Birthdate: ____/____/____

Graduation Year: _____
Student Cell Phone: _____
Student Email: _____
Primary Telephone: _____

PARENT/GUARDIAN INFORMATION - 1st CONTACT

Parent/Guardian: _____
Relationship (Circle One): Parent Step-Parent Grandparent
Uncle/Aunt Brother/Sister Legal Guardian (circle one)
Other: _____

Place of Employment: _____

Work Telephone: _____ Extension _____

Cell Phone: _____ E-mail _____

Mr. Mrs. Ms.
Lives with student? Y N
Occupation: _____

PARENT/GUARDIAN INFORMATION - 2nd CONTACT

Parent/Guardian: _____
Relationship (Circle One): Parent Step-Parent Grandparent
Uncle/Aunt Brother/Sister Legal Guardian (circle one)
Other: _____

Place of Employment: _____

Work Telephone: _____ Extension _____

Cell Phone: _____ E-mail _____

Mr. Mrs. Ms.
Lives with student? Y N
Occupation: _____

ADDITIONAL EMERGENCY CONTACTS

In an emergency, who should be contacted after attempting 1st and 2nd contact?

3) Name: _____
Relationship to Student: _____ Daytime Telephone: _____

4) Name: _____
Relationship to Student: _____ Daytime Telephone: _____

5) Name: _____
Relationship to Student: _____ Daytime Telephone: _____

Are there situations regarding custody of which the school should be aware?

Y N (CIRCLE ONE) If yes, please explain: _____

Doctor Name: _____ Office Phone: _____

My son/daughter can enroll in a regular P.E. course: Y N (CIRCLE ONE)

STUDENT May have Tylenol? YES NO

MI

First

Last Name (please print)

STUDENT

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Authorization to Consent to Treatment of Minor and Permission to Transport form.

(I) (We), the undersigned, parent(s)/legal guardian(s) of _____, a minor, do hereby give permission to BISHOP MONTGOMERY HIGH SCHOOL and/or their agent to transport my son/daughter/ward in case of an emergency.

(I) (We), the undersigned, parent(s)/legal guardian of said minor do hereby authorize BISHOP MONTGOMERY HIGH SCHOOL as agent 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 special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the diagnosis or treatment 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 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.

I understand that any insurance benefits that are effective have limited application.

Health Information: Please check all that pertain to your child:

<input type="checkbox"/> eye glasses	<input type="checkbox"/> contact lenses	<input type="checkbox"/> asthma	<input type="checkbox"/> nosebleeds
<input type="checkbox"/> convulsions	<input type="checkbox"/> diabetes	<input type="checkbox"/> epilepsy	<input type="checkbox"/> fainting
<input type="checkbox"/> heart trouble	<input type="checkbox"/> frequent headaches		<input type="checkbox"/> allergies (Please list)

Please list any prescribed medication your child takes **routinely**:

Please describe any other health condition(s) of which the school should be made aware:

Primary Insurance Carrier: _____ Policy Number: _____

Signature of Legal Guardian

Signature of Legal Guardian

Relationship to Minor

Relationship to Minor

Date: _____

PLEASE NOTIFY THE ATTENDANCE OFFICE IMMEDIATELY OF ANY CHANGES.