



**OAKS CHRISTIAN SCHOOL
2017 EMERGENCY AND MEDICAL AUTHORIZATION FORM
EFFECTIVE FOR 1 YEAR FROM DATE OF EXECUTION**

Student may NOT begin summer programs without an Emergency Information Agreement/Medical Authorization Form on file.

Student's Last Name:		First Name:		Middle Name:		Gender:		Grade in Aug. 2017	
Date of Birth: / /		Age:		Student's Cell Phone:		Soccer Camp(s) in summer:			
PLEASE <input checked="" type="checkbox"/> STUDENT LIVES WITH: <input type="checkbox"/> BOTH PARENTS <input type="checkbox"/> MOTHER % <input type="checkbox"/> FATHER % <input type="checkbox"/> OTHER %									
PARENT/GUARDIAN 1					PARENT/GUARDIAN 2				
<i>Mr., Mrs., Ms., Dr. (Please Circle One)</i> First and Last Name:					<i>Mr., Mrs., Ms., Dr. (Please Circle One)</i> First and Last Name:				
Relationship to Student:					Relationship to Student:				
Home Address:					Home Address:				
City, State, Zip:					City, State, Zip:				
E-Mail:					E-Mail:				
Home Phone:			Cell Phone/Pager:		Home Phone:			Cell Phone/Pager:	
Business Name & Phone:					Business Name & Phone:				

EMERGENCY CONTACTS (MUST INCLUDE ONE CONTACT)

PLEASE LIST THREE LOCAL PEOPLE (OTHER THAN PARENT OR GUARDIAN) AS EMERGENCY CONTACTS:

Contact 1 Name:			Relationship to Student:			Home Phone:		
Authorized to pick up? <input type="checkbox"/> Yes <input type="checkbox"/> No			Work Phone:			Cell Phone/Pager:		
Contact 2 Name:			Relationship to Student:			Home Phone:		
Authorized to pick up? <input type="checkbox"/> Yes <input type="checkbox"/> No			Work Phone:			Cell Phone/Pager:		
Contact 3 Name:			Relationship to Student:			Home Phone:		
Authorized to pick up? <input type="checkbox"/> Yes <input type="checkbox"/> No			Work Phone:			Cell Phone/Pager:		
If possible, please list an out-of-state contact (for use in case of disruption of local phone lines):								
Name/Relationship to Student:			Home Phone:			Cell Phone/Pager:		
City/State:			Work Phone:					

MEDICAL CONTACTS

Physician's Name:		City:		Phone:		Date of last exam:	
Dentist:		City:		Phone:		Date of last exam:	
Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No		Drugs, food, medications, etc.?					
Comments:							
Other Medical conditions or surgeries: <input type="checkbox"/> Yes <input type="checkbox"/> No				Describe:		Treatment:	
Does child have hearing difficulty? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does child wear: <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Brace <input type="checkbox"/> Prosthesis					
Date of Last Tetanus:							

NON-PRESCRIPTION MEDICATION:

PLEASE CHECK **THE APPROPRIATE BOX(ES)** Acetaminophen (Tylenol) Ibuprofen (Advil, Motrin) Diphenhydramine HCL (Bendryl) Antacids (Tums, Mylanta)

PRESCRIPTION MEDICATION:

PLEASE LIST ALL CURRENT MEDICATION AND REASONS FOR TAKING:

	TAKEN AT HOME?	TAKEN AT SCHOOL?	EMERGENCY ONLY
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

OPTION ONE: Oaks Christian School is authorized to administer the above medications/remedies to my child. I agree to notify the school in writing of any changes in my child's condition with respect to the administration of medication/remedies or with any changes to the information provided on this form. I understand that the school will have limited liability while administering medication.

OPTION TWO: Oaks Christian School is NOT authorized to administer any medication without parent or guardian consent.

Parent/Guardian Signature: _____ Date: _____

(PLEASE CONTINUE ON THE BACK OF THIS FORM.)



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Parental Authorization to Consent to Treatment of Minor

Parent Name: _____ (Herein "Parent") Parent Name: _____ (Herein "Parent")

Student Name: _____ (Herein "Minor")

The above named Parent of the Minor has entrusted, for a temporary period of time, the Minor into the care of Oaks Christian School and its Agent, an adult, for particular reasons and for the welfare of the Minor.

The parent does hereby authorize the Agent, as agent for the undersigned to any x-ray examination, anesthetic, emergency Paramedic treatment, 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 and surgeon licensed under the provisions of the Modern Medical Practice Act or the medical staff of any hospital; or to consent to x-ray examination, anesthetic dental or surgical diagnosis or treatment to be rendered to the Minor by any dentist licensed under the provisions of the Dental Practice Act.

It is understood that this authorization is given in advance of any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care being required but is given to provide authority and power on the part of the Agent to give specific consent to any and all such examination, anesthetic, diagnosis, treatment or hospital care which the aforementioned surgeon, physician and/or dentist, in the exercise of his/her best judgment, may deem advisable. This authorization, and the attached Caregiver's Authorization Affidavit are given pursuant to the provisions of Section 6550 and 6910* of the Family Code of California.

The parent hereby authorizes any hospital which has provided treatment to the Minor pursuant to the provisions of Section 6550 and 6910* of the Family Code of California to surrender physical custody of the Minor to the Agent upon the completion of treatment. This authorization is given pursuant to Section 1283** of the Health and Safety Code of California.

These authorizations shall remain effective for one year from date of signing unless sooner revoked in writing delivered to said Agent.

*Family Code of California, Section 6910

The parent, guardian, or caregiver of a minor who is a relative of the minor and who may authorize medical care and dental care under Section 6550, may authorize in writing an adult into whose care a minor has been entrusted to consent to medical care or dental care, or both, for the minor.

**Health and Safety Code, Section 1283 (a)

No health facility shall surrender the physical custody of a minor under 16 years of age to any person unless such surrender is authorized in writing by the child's parent, the person having legal custody of the child, or the "Caregiver of the child and who may authorize medical care and dental care under Section 6550 of the Family Code".

Parent/Legal Guardian Signature Date Parent/Legal Guardian Signature Date