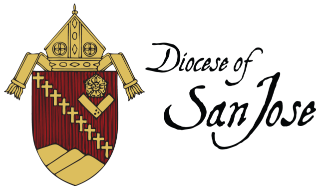

UNIVERSAL MEDICAL INFORMATION
EMERGENCY CONTACT / RELEASE AND CONSENT FORM

ST. MARY'S SCHOOL
30 LYNDON AVENUE
LOS GATOS, CA
2016 - 2017

STUDENT INFORMATION

Last Name | **First Name** | **Middle Name**

Grade | **Homeroom Teacher** | **Date of Birth**

Street Address | **City** | **State** | **Zip**

SIBLINGS ENROLLED AT SCHOOL

NAME	GRADE	HOMEROOM TEACHER

STUDENT LIVES WITH (Check all that apply): ***Person to call first in case of emergency***

_____Mother
_____Father
_____Guardian(s) Specify Relationship ____

PARENT/GUARDIAN INFORMATION Specify: _____Father _____ Mother _____ Guardian

Last Name | First Name | Middle Initial

Home Street Address/Apt. or Unit # | City | State | Zip

Home Phone | Cell Phone

Name of Employer | Company Address | City/State/Zip

Work Phone | Cell Phone

PARENT/GUARDIAN INFORMATION Specify: _____ Father _____ Mother _____ Guardian

Last Name | First Name | Middle Initial

Home Street Address/Apt. or Unit # | City | State | Zip

Home Phone | Cell Phone

Name of Employer | Company Address | City/State/Zip

Work Phone | Cell Phone

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PARENT/GUARDIAN INFORMATION **Specify:** ______**Father** ______**Mother** ______**Guardian**

Last Name First Name Middle Initial

Home Street Address/Apt. or Unit # City State Zip

Home Phone Cell Phone

Name of Employer Company Address City, State, Zip

EMERGENCY CONTACT INFORMATION

Name	Address	Best Contact Phone Number_____

STUDENT PHYSICIAN INFORMATION

Primary Physician Address Phone

Emergency Physician Address Phone

STUDENT EXISTING MEDICAL INFORMATION

Medical Condition(s) (e.g., asthma, diabetes, epilepsy, heart conditions, ADHD, etc):________________________

____

____

____

Disabilities (physical, learning, etc):____

____

____

List medications taken/frequency: ____

____

____

Allergies to Medications: ____

____

____

UNIVERSAL MEDICAL INFORMATION
EMERGENCY CONTACT / RELEASE AND CONSENT FORM

CONSENT TO TREATMENT OF CHILD AND HANDLING OF CONFIDENTIAL INFORMATION

I, ______________________________________, parent/legal guardian of ______________________________________,
Parent/Legal Guardian's Name *Student Name*
student at ________________________________, have read, understood, and consent to the following:
School

First-Aid/Emergency Treatment: Without limiting other emergency powers that may be provided by law, I authorize school personnel to administer first-aid to my child if the school administration deems it necessary and appropriate to preserve the life, limb or well-being of my child. If the school administration believes, in its sole discretion, that a medical necessity exists beyond that which can reasonable be dealt with on school grounds by school personnel, I authorize the school to contact and engage qualified medical personnel and arrange for emergency treatment of my child, including transportation either by school staff or by professional transport for medical, dental, surgical or hospital care or diagnosis, and I consent to that treatment for my child. Arrangements for treatment will be made in the following order of priority: 1) the "emergency physician" listed above; 2) the "primary physician" listed above; 3) another physician or health-care professional licensed by the State of California. I understand and agree that I will be financially responsible for any such medical treatment.

In consideration of the arrangement indicated in this paragraph, the undersigned hereby releases and discharges the Diocese of San Jose, its constituent organizations, including but not limited to The Roman Catholic Welfare Corporation, the Department of Education and St. Mary's School, and their respective officers, agents, and employees (the "Diocese") for any and all claims for personal injuries or property damage that I or my child may suffer as a result of this arrangement whether or not such injuries or damages be caused by the negligence (whether active or passive) of any of the entities or individuals named or described above, excepting only injuries or damage resulting from Diocese's willful misconduct.

____
Signature of Parent/Legal Guardian Date

1. Release of Student to Qualified Emergency/Medical Personnel and Third Parties: Without limiting other emergency powers as may be allowed by law, in the event of disaster or medical necessity involving the life, limb or well-being of my child in which it is necessary in the opinion of the school administration to transport my child from school property, or if it is necessary to evacuate the school grounds, the school will make a reasonable effort (in view of the nature of the necessity) to first contact a parent or legal guardian. If no parent/legal guardian is available, I authorize the school to release my child into the custody of third parties for the purpose of transporting my child from school grounds and arranging for such care as my child may need, in the following order of priority: 1) the persons listed above as emergency contacts; 2) qualified medical/emergency professionals; 3) another responsible adult.

2. Gathering, Use and Release of Medical Information: Without limiting other emergency powers that may be provided by law, in the event of disaster or medical emergency, I specifically authorize the gathering, use and release to, from, and among the school personnel and to, from and among any medical professionals, of any medical information reasonably necessary to provide emergency medical care and otherwise ensure the life, limb and well-being of my child, including without limitation, the information contained in this form, until I can reasonable be notified and take custody of my child. I understand that this information will be requested, gathered and/or released only for the purpose of providing first-aid or emergency medical care necessary in the absence of a parent or legal guardian, or as otherwise allowed by law.

3. General Terms of Parental Consent

CONFIDENTIAL MEDICAL OR EDUCATIONAL INFORMATION AS SET FORTH IN THIS FORM WILL BE GATHERED, USED AND DISSEMINATED ONLY BY THE PERSONS AND ONLY FOR THE PURPOSES SET FORTH HEREIN, OR AS OTHERWISE ALLOWED BY LAW.

THIS AUTHORIZATION IS EFFECTIVE ONLY FOR THE SCHOOL YEAR LISTED ABOVE, AND WILL EXPIRE ON JUNE 15 OF EACH SCHOOL YEAR. IT MAY BE REVOKED AT ANY TIME IN WRITING SIGNED BY EITHER PARTY. IF REVOKED, THE SCHOOL RESERVES THE RIGHT TO SUSPEND OR TERMINATE THE ATTENDANCE OF THE CHILD AT THE SCHOOL.

I AGREE TO AND CONSENT TO THE ACTIONS SET FORTH HEREIN AND HEREBY GRANT AUTHORIZATION OF THE SCHOOL TO OBTAIN AND USE MEDICAL INFORMATION AND RECORDS BY THE PERSONS, FOR THE PURPOSES, AND DURING THE TIME SET FORTH ABOVE.

I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A TRUE COPY OF THIS AUTHORIZATION. BY MY SIGNATURE, I ACKNOWLEDGE THAT A TRUE COPY OF THIS AUTHORIZATION HAS BEEN RECEIVED BY ME.

____
Signature Print Name Date Relationship to Child

____
Signature Print Name Date Relationship to Child