FOREST RANCH CHARTER SCHOOL
Emergency Information/Consent to Treat

Student's Name: LAST_____ FIRST_____ Grade_____ ID#_____

Birthdate _____ Home Phone _____ E-mail address _____

Mailing Address _____ City_____ Zip_____

Living with (please circle): mother/stepmother   father/stepfather   guardian (relationship) _____

Father/guardian name _____ Employer _____
    Work Phone _____ Cell/Pager _____ Work Hours _____
    Position/Occupation _____ E-Mail address _____
Mother/guardian name _____Employer _____
    Work Phone _____ Cell/Pager _____ Work Hours _____
    Position/Occupation _____ E-Mail address _____
If parent is not living with student, parent name _____ Phone _____
  Address_____ City _____ State _____ Zip _____

List persons not living in the home who can come for student or give permission to leave campus if unable to locate parent.

1. Name_____ Relationship_____ Phone_____
2. Name_____ Relationship_____ Phone_____
3. Name_____ Relationship_____ Phone_____

Other children in family
1. Name_____ School_____ Grade_____
2. Name_____ School_____ Grade_____
3. Name_____ School_____ Grade_____

I (We), the undersigned, parent, parents, or legal guardian of _____, a minor, do hereby authorize and consent to any X-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the medicine practice act and on the staff of any acute general hospital holding a current license to operate from the State of California Department of Public Health. 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 to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that none of the above treatment will be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of Section 25.8 of Civil Code of California.

LIST OF RESTRICTIONS_____

ALLERGIES TO DRUGS OR FOODS_____

LIST ANY SPECIAL MEDICATIONS OR ANY MEDICAL CONDITIONS_____
_____

Date of last TETANUS BOOSTER_____

IN CASE OF EMERGENCY AND PARENT OR GUARDIAN CANNOT BE REACHED, SCHOOL IS AUTHORIZED TO CALL
    LOCAL DOCTOR_____ ADDRESS_____ PHONE_____
    LOCAL DENTIST_____ ADDRESS_____ PHONE_____

I declare under penalty of perjury that the foregoing is correct.
SIGNATURE OF_____ DATE_____
        Father (or)   Mother   (or)   Legal Guardian