San Luis Obispo Christian School

EMERGENCY INFORMATION & AUTHORIZATION TO PICK-UP
_____SCHOOL YEAR

Student's Name _____ Date of birth _____

Parents' Names _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Alternate Phone _____

PARENT EMPLOYER INFORMATION

Mother's Employer _____
Work Phone _____ Ext. _____

Father's Employer _____
Work Phone _____ Ext. _____

NAMES OF PERSONS AUTHORIZED TO PICK-UP CHILD AT SCHOOL

Name	Relationship	Phone #	Emergency Contact (Y/N)

MEDICAL INFORMATION

Student's Primary Physician _____

Address _____ Phone _____

Insurance Co. _____ Policy # _____

LIST ALL ALLERGIES AND MEDICAL PROBLEMS

In case of an emergency, I authorize a staff member or representative of San Luis Obispo Christian School to take my child to a medical facility for such emergency treatment and measures as are deemed necessary for the safety and protection of the child. I understand that I am responsible for any medical expenses incurred.

_____ _____
Signature of Parent or Guardian Date

☐ I, authorize SLOCS staff to dispense Tylenol to my child.

_____ _____
Signature of Parent or Guardian Date

San Luis Obispo Christian School

EMERGENCY INFORMATION & AUTHORIZATION TO PICK-UP

Student's Name _____

I do hereby authorize consent to an agent of San Luis Obispo Christian School, in whose care my child has been entrusted while attending school and school sponsored outings, to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendering to my child. This consent is authorized only under the general or special supervision and upon advice of a physician a/or surgeon licensed under the provisions of the Medical Practice Act. I further consent to an x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to my child by a dentist licensed under the provision of the Dental Practice Act.

It is further understood that this authorization is give en in advance of any specific diagnosis, treatment, or hospital care being required. It is given to provide authority and power on the part of San Luis Obispo Christian School agents to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician or dentist in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provision of Section 25.8 of the Civil Code of California and shall remain effective as long as the student is enrolled, unless sooner revoked in writing and delivered to said agent.

This undersigned persons has legal custody of the student named above and do give authorization as stated above.

_____ _____

Mother (or Guardian) Date

_____ _____

Father (or Guardian) Date

Student Medical Information

Physician's Name _____ Phone _____

Dentist's Name _____ Phone _____

If physician cannot be reached what action should be taken?

Call Emergency Hospital _____ Other _____

Specific medical information (allergies, medications, problems, conditions, etc.)

_____

_____

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