EXTENDED CARE STUDENT EMERGENCY INFORMATION 2012-2013

Please complete one form per child.

Student____ Grade/Class__________

Date of Birth_________________ Age________ Teacher______________________________

Student's Home Address	Other Home Address

PRIMARY CONTACT / Custodian Name			Relation to Child
Home Address / City / Zip			Home Phone
Place of Employment / City		Position	Work Hours
Work Phone	Fax	Cellular	Pager

If unable to reach person above, please contact:

SECONDARY CONTACT / Custodian Name			Relation to Child
Home Address / City / Zip			Home Phone
Place of Employment / City		Position	Work Hours
Work Phone	Fax	Cellular	Pager

Other Contacts: *persons to contact if above persons are not available* ***(THIS MUST BE COMPLETED)***

Contact #1			Relation to Child
Home Address			Home Phone
Work Phone	Fax	Cellular	Pager

Contact #2			Relation to Child
Home Address			Home Phone
Work Phone	Fax	Cellular	Pager

Health Information: *please check (Y) if your child has any unusual medical conditions*

☐ Asthma	☐ Bee Sting Allergy	☐ Internal Irregularities	☐ Deafness	☐ Physical Handicap (Describe): ______
☐ Kidney	☐ Other Allergy	☐ Convulsive Seizures	☐ Surgical	
☐ Arthritis	______	☐ Sight Impairment	☐ Fractures	
☐ Diabetes	☐ Mild ☐ Severe	☐ Wears Glasses	☐ Heart	☐ Other:

Preferred Hospital	Persons allowed to pick up child
Preferred Physician	

Waiver for Medical Treatment

If emergency treatment is required, and the parents or legal guardians cannot be reached immediately, your signature in the space provided below empowers All Saints School to exercise their own judgment in calling the physician indicated above or, if not available, to transport the child to a hospital emergency room. Likewise, your signature below is not sufficient for the release of confidential information protected by Federal Law.

Custodian's Signature____Date______________

PROVIDENCE MEDICAL CENTER
4805 N.E. GLISAN
PORTLAND, OREGON 97213-2967
PHONE: 503/230-1111

PROVIDENCE MILWAUKIE HOSPITAL
10150 S.E. 32ND AVENUE
MILWAUKIE, OREGON 97222
PHONE: 5031652-6300

ST. VINCENT HOSPITAL AND MEDICAL CTR
9205 SOUTHWEST BARNES ROAD
PORTLAND, OREGON 97225
PHONE: 5031297-4411

AUTHORIZATION FOR ANOTHER TO *CONSENT* TO *TREATMENT* OF *CHILD*

As a parent or legal guardian of the following children:

X____

I hereby authorize *-All Saints Extended Care*
Name

601 NE 39th Avenue, Portland, OR 97232 (503) 314-9398
Address and Phone Number

who is 18 years of age or older, to consent to any medical or surgical treatment of above children which such person deems advisable If a parent or legal guardian cannot reasonably be located when the children are brought for treatment.

The above authorization will be effective as *September 1, 2012* and will expire after *June 30, 2013*

(Total period by law may not exceed six (6) month or twelve (12) months for school administrator.)

During this period the parent or legal guardian of the above children will be at the following location(s):

X ____

X Signature: ____

Witnessed by: ______________________________

Home Address of Parent or Guardian: ______________________________

Phone Number of Parent or Guardian: ______________________________

Family Physician: ____________________ Phone Number: ______________

Address of Physician: ____

Family Dentist: ____________________ Phone Number: ______________

Address of Dentist: ____

Employer: ____________________ Phone Number: ______________

Health Insurance Company: ______________ Group Number: ______________

Name of Child				
Chronic Illnesses or Allergies				
Date of Last D.P.T. Immunizations				
Other				