

St. Francis Health and Release Form

Name of Child/Student # 1: _____
Allergies to Drugs or Food: _____
Any Special Medications or Pertinent Information: _____

Name of Child/ Student #2: _____
Allergies to Drugs or Food: _____
Any Special Medications or Pertinent Information: _____

Child/ Student # 3: _____
Allergies to Drugs or Food: _____
Any Special Medications or Pertinent Information: _____

Parents or Legal Guardians:

(Parents' Names) (cell Phone # or contact on Sunday morning)

_____ or other number (s) to call when Child is in Class?

EMERGENCY ALTERNATE CONTACT:

(Name) (Relationship)

(Phone #)

Physician:

(Phone #) _____

City: _____

AUTHORIZATION TO TREAT A MINOR (or Minors)

I (we) the undersigned parent, parents, or legal guardian of

_____, a minor (or minors), do hereby authorize and consent to the physician, nurse, dentist, or licensed care staff selected by the present supervisory personnel to render medical, dental or other appropriate treatment deemed necessary by immediate by the licensed medical care staff. It is understood that this authorization is given in advance of any specific power to render care which the fore mentioned 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 any of the above treatment will not be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

Signature of Father, Mother or Legal Guardian _____ Date _____

Address _____ City _____ State _____ Zip Code _____

This consent shall remain effective from *Sept 2009 - June 2010*