Cuddeback Union Elementary School
Emergency Care Information

Please Press Firmly

Student's Name ______________________ Teacher ______________ Grade ____
Student's Birthdate ______________________ Male ____________ Female ____________
Home Phone ______________________ Cell Phone ______________________
Mailing Address ____
Home Address ____
Email ____
Student lives with: Mother _____ Father _____ Both _____ Guardian _____ Other __________
Mother's Name ______________ Employer ______________ Business Phone __________
Address ______________ Cell Phone ______________ Home Phone __________
Father's Name ______________ Employer ______________ Business Phone __________
Address ______________ Cell Phone ______________ Home Phone __________

If the family should be gone, list two relatives, friends, or neighbors who will assume temporary care or responsibility in their absence.
Name ______________________ Phone ______________ Relationship __________
Name ______________________ Phone ______________ Relationship __________

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In the event of an EMERGENCY/DISASTER list one person who your student may be released to:
Name ______________________ Phone ______________ Relationship __________
This is so that in the event that all communication were down, you would know that your student is at school or with the above said person.

Permission To Walk Home

(Please check one)

My child has permission to walk to and/or from school daily. ☐
My child does not have permission to walk to and/or from school daily. ☐

Parents: Please indicate any significant health problems concerning your son/daughter that the school should be aware of:

____

____

Any Special Medications? ______________________ Inhaler Needed? __________
Your Physician's Name ______________________ Phone __________
Parent/Guardian's Signature ______________________

Authorization to Consent To Treatment Of Minor

(I) (We), the undersigned, parent(s) of______________________a minor, do hereby authorize CUDDEBACK SCHOOL as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or speccial supervision of, any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.
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 on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the excercise or his/her best judgement may deem advisable.
This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.
(I) (We) hereby authorize any hospital which has provided treatment to the above-named minor pursuant to the provisions of Section 25.8 of the Civil Code of California to surrender physical custody of such minor to (my) (our) above-named agent(s) upon the completion of treatment.
This authorization is given in pursuant to Section 1283 of the Health and Safety Code of California.
These authorizations shall remain effective until ____________, 20____, unless sooner revoked in writing delivered to said agent(s).

Date______________ Parent/Legal Guardian______________________________

ALL COPIES OF THIS FORM ARE TO BE RETURNED TO SCHOOL