

EMERGENCY INFORMATION

1 Name: _____ Grade: _____
last, first, middle

As the parent, agency representative or legal guardian, I hereby give consent to Trinity Christian School to provide all emergency dental or medical care prescribed by a duly licensed physician (MD) or dentist (DDS) for my child (named above) for the school year. This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my dependent. This authorization is given pursuant to the provisions of section 25.8 of the civil code of California.

2 Date: _____ (Father, Mother or Legal Guardian - signature) _____
Address: _____ Phone: _____

Date of Birth: _____ Place of Birth: _____ Age: _____

Mother's Name: _____ Work: _____ Phone: _____ Cell: _____

E-Mail: _____ Occupation: _____ Talent: _____

Father's Name: _____ Work: _____ Phone: _____ Cell: _____

E-Mail: _____ Occupation: _____ Talent: _____

Adult (other than parent) authorized to take child from school in case of an emergency.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Person **NOT AUTHORIZED** to take child from school:

Name: _____ Phone: _____ Relationship: _____

SEE OTHER SIDE



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EMERGENCY INFORMATION

3 SIBLINGS OF STUDENT:

Name: _____ Age: _____ Sex: _____ School Attending: _____
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4 OTHER ADULTS LIVING IN THE HOME OTHER THAN PARENTS:

Name: _____ Relationship to the Student: _____
Name: _____ Relationship to the Student: _____

5 HEALTH DETAILS:

Allergies, physical limitations, special health concerns, medications required, etc.

Doctor's Name: _____ Phone: _____

Medical Insurance Information:

Medical Insurance Carrier _____ Policy Number: _____

We carry no medical insurance at this time:

Other important information regarding emergencies: _____



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