

**FOREST RANCH CHARTER SCHOOL**  
**Emergency Information/Consent to Treat**

Student's Name: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ Grade \_\_\_\_\_ ID# \_\_\_\_\_

Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_ E-mail address \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Living with (please circle): mother/stepmother father/stepfather guardian (relationship) \_\_\_\_\_

Father/guardian name \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_ Work Hours \_\_\_\_\_

Position/Occupation \_\_\_\_\_ E-Mail address \_\_\_\_\_

Mother/guardian name \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_ Work Hours \_\_\_\_\_

Position/Occupation \_\_\_\_\_ E-Mail address \_\_\_\_\_

If parent is not living with student, parent name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**List persons not living in the home who can come for student or give permission to leave campus if unable to locate parent.**

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

3. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Other children in family**

1. Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

2. Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

3. Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

I (We), the undersigned, parent, parents, or legal guardian of \_\_\_\_\_, a minor, do hereby authorize and consent to any X-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the medicine practice act and on the staff of any acute general hospital holding a current license to operate from the State of California Department of Public Health. 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 to render care which the aforementioned 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 none of the above treatment will be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of Section 25.8 of Civil Code of California.

LIST OF RESTRICTIONS \_\_\_\_\_

ALLERGIES TO DRUGS OR FOODS \_\_\_\_\_

LIST ANY SPECIAL MEDICATIONS OR ANY MEDICAL CONDITIONS \_\_\_\_\_

Date of last TETANUS BOOSTER \_\_\_\_\_

IN CASE OF EMERGENCY AND PARENT OR GUARDIAN CANNOT BE REACHED, SCHOOL IS AUTHORIZED TO CALL

LOCAL DOCTOR \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

LOCAL DENTIST \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

I declare under penalty of perjury that the foregoing is correct.

SIGNATURE OF \_\_\_\_\_ DATE \_\_\_\_\_

Father (or) Mother (or) Legal Guardian

Name, address and phone number will be used in the school directory.

Please check here \_\_\_\_\_ if you do **NOT** wish your information to be in the directory.