☐Check here if address/telephone has changed in past year.

STUDENT'S NAME (last/first)_____GRADE_____ID#_____

SOCIAL SECURITY#_____BIRTHDATE_____TELEPHONE_____

ADDRESS_____ZIP CODE_____APT._____SPACE_____

FATHER'S NAME_____ADDRESS_____
(if different from student's)

MOTHER'S NAME_____ADDRESS_____
(if different from student's)

FATHER'S EMPLOYER_____PHONE_____EXT._____WRK. HRS._____

MOTHER'S EMPLOYER_____PHONE_____EXT._____WRK.HRS._____

CELLULAR PHONE OR PAGER NUMBERS - MOM:_____DAD:_____

List relatives/friends not living in the home that can come for student or give permission to leave campus if unable to locate parent.

1. NAME:_____RELATIONSHIP_____DAYTIME PHONE_____
2. NAME:_____RELATIONSHIP_____DAYTIME PHONE_____
3. NAME:_____RELATIONSHIP_____DAYTIME PHONE_____

OTHER CHILDREN IN FAMILY:

1. NAME:_____GRADE_____ SCHOOL _____
2. NAME:_____GRADE_____ SCHOOL_____
3. NAME:_____GRADE_____ SCHOOL_____

●TURN CARD OVER●

HS-10b (2/18/98) White

SCHOOL_____ DATE_____

AUTHORIZATION TO TREAT MINOR

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 a hospital 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 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 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_____

INSURANCE COMPANY_____POLICY #_____

I declare under penalty of perjury that the foregoing is correct. STUDENT INSURANCE: YES____ NO____
Yo declaro bajo pena de perjurio que lo anteriormente dicho es correcto.
SIGNATURE OF:_____

(1) FATHER (2)MOTHER (3)LEGAL GUARDIAN_____