



Bishop Alemany High School – Emergency Information Card

Parent Information: Please complete this card and return card to school. In a major emergency, it is school policy to retain students at school for their safety. This card will be used by school staff when students are released to go home.

PLEASE PRINT LEGIBLY.

Student's Date of Birth _____

Student's Last Name	First	Initial	Grade	Gender	Home Phone No.	Home Language
Home Address Number	Street	Apt#	City	Zip	Student's Cell Phone No.	
Parent/Guardian #1	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Other _____			
Last Name	First	Address				
Business	Address			Occupation		
Daytime Phone	Cell Phone		Email			
Parent/Guardian #2	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Other _____			
Last Name	First	Address				
Business	Address			Occupation		
Daytime Phone	Cell Phone		Email			
To the Principal: In case you are unable to reach me during the day emergency, you are authorized to contact and if necessary release my child to any of the following:						
Name	Address			Daytime Phone		Relationship
Name	Address			Daytime Phone		Relationship
Name	Address			Daytime Phone		Relationship

Does your child have any brothers or sisters attending this school? <input type="checkbox"/> No <input type="checkbox"/> Yes - If so, please list below:		
Last Name	First Name	Grade
Last Name	First Name	Grade
Last Name	First Name	Grade

Authorization for Emergency Medical Treatment

The undersigned, legal custodian of _____ (Student Name) a minor, hereby authorizes the principal or designee, into whose care the aforementioned minor pupil has been entrusted to consent to any x-ray examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to said minor upon the advise of any licensed physician and or dentist. It is understood that this authorization is given in advance of any required diagnosis treatment or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis treatment, or hospital care which a licensed physician or dentist may deem necessary. This authorization is given and shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand that BAHS its officers, its employee assume no liability of any nature in relation to the transportation of the said minor. I further understand that all costs of paramedic transportation, hospitalization and any examination, X-ray or treatment provided in relation to this authorization shall be borne by the undersigned.

Doctor's Name	Daytime Phone#	Address
Medical Plan	Group #	Subscriber #

My child is allergic to the following medications: _____

Other medications used: _____ Any medical conditions _____ Wears Glasses/Contacts Yes/No

Dentist's Name	Daytime Phone#	Address
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Signature of Parent/Guardian 1 _____ Signature of Parent/Guardian 2 _____

For School Use Only

Student released to: Name:	
Location to where student was taken:	
Official Releasing Student:	Date/ Time