Visitor Emergency Information and Consent To Medical, Surgical or Dental Examination/Treatment

Crestmont School

6226 ARLINGTON BLVD • RICHMOND, CA 94805 • (510) 237-4164

CHILD'S FULL NAME: _____

PARENT/GUARDIAN'S FULL NAME: _____

CONTACT PHONE NUMBER FOR DAY OF VISIT: _____

ALTERNATE CONTACT PHONE: _____

CONTACT ADDRESS ON DAY OF VISIT: This is a ❑ work ❑ home ❑ other address _____

_____ ZIP: _____

OUT-OF-STATE CONTACT NAME AND ADDRESS:

_____

_____ OUT OF STATE PHONE _____

SPECIAL MEDICAL INFORMATION (allergies, etc.): _____

_____

I am sending the following medication (provide written directions and dosages):

_____

HEALTH INSURANCE NAME AND #: _____

PHYSICIAN NAME AND PHONE #: _____

DENTIST NAME AND PHONE #: _____

I GIVE MY PERMISSION FOR MY SON/DAUGHTER/WARD, _____

WHILE VISITING CRESTMONT TO RECEIVE WHATEVER MEDICAL CARE DEEMED NECESSARY BY A PHYSICIAN OR DENTIST IN THE CASE OF AN EMERGENCY DURING MY ABSENCE.

DATE _____ PARENT/GUARDIAN SIGNATURE _____