St. Patrick SUCCEED Academy Clubhouse Program
5945 Franklin Blvd Sacramento, CA 95824 (916)
EMERGENCY INFORMATION

Last Name of Child | First | Middle | Phone

Address | Zip code | Date of Birth | Phone

Mother's Name | Address | Phone

Name and Address of Employer | Hours | Phone

Father's Name | Address | Phone

Name and Address of Employer | Hours | Phone

OTHER PERSONS TO CALL IN CASE OF EMERGENCY:

Name | Address | Phone | Relationship

Name | Address | Phone | Relationship

NAMES OF PERSONS AUTHORIZED TO PICK CHILD UP FROM EXTENSION

_____ _____

_____ _____

Does child have any special health needs? _____

_____

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

In the event of serious emergency, and none of the emergency persons can be contacted, I authorize school officials to call my family doctor or, if the Situation demands, to transfer my child to the nearest hospital for the necessary emergency care. I consent to any X-ray, examination, and anesthetic Medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervisions Of any physician and surgeon licensed under the provisions of the Medicine Practice Act, or the Medical staff of a certified hospital, whether such Diagnosis or treatment is rendered at the office of the physician or at the hospital.

I understand that the school does not assume responsibility for payment of a physician. If our family physician cannot be reached, the school may choose A physician Yes _____ No _____

Name of Family Physician _____ Phone_____

Name of Family Dentist _____ Phone_____

Signature of Parent or Guardian_____ Date_____

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