



Failure to complete all portions of this form could result in an injury or compound the damage of an injury.

Student Information

Name (Last): \_\_\_\_\_ (First): \_\_\_\_\_ Grade: \_\_\_ Gender: \_\_\_  
Birthplace: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_

CHECK ONE:  
 New student  
 Returning student

Emergency Contact Information

Parent 1: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Fax: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Pager: \_\_\_\_\_  
Parent 2: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Fax: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Pager: \_\_\_\_\_  
Other emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Physician/Insurance Information (Failure to complete could result in a delay in care)

Is student covered by any hospital/medical care policy? Yes \_\_\_\_\_ No \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_ Policy/Group No.: \_\_\_\_\_  
Name of Policy Holder: \_\_\_\_\_ Social Security No. of Policy Holder: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Does insurance company require preauthorization? Yes \_\_\_ No \_\_\_ If yes, preauthorization phone: \_\_\_\_\_  
Doctor : \_\_\_\_\_ Dr. Phone: \_\_\_\_\_

Required Immunization

Immunization	Last date on file	Requirement	Date of latest Immunization
Tetanus		Within 5 years of program start	

Brief Medical History (to be completed by parents annually)

Allergies (including medicines, foods, bites and stings) NONE: <input type="checkbox"/>		
Allergy	Reaction	Medication Required

  

Medications (List any medications you are using, including psychiatric and over-the-counter medication. NONE: <input type="checkbox"/>			
Medication	Condition	Dosage (size & frequency)	Current Side Effects

Authorization to Treat a Minor

I(We) the undersigned parents(s) or legal guardian of \_\_\_\_\_, a minor, do hereby authorize and consent to any x-ray examination, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under 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 or 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 authorizes and empowers the aforementioned physician in the exercise of his best judgment to render care, which he 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.

List any restrictions: \_\_\_\_\_  
\_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_ (OVER)

