



JUSTIN-SIENA HIGH SCHOOL

COLLEGE PREPARATORY

CATHOLIC, LASALLIAN EDUCATION FOR THE 21ST CENTURY

EMERGENCY CONTACT AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

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This must be completed at the beginning of each school year

(I), (We), the undersigned, parent(s) of the minor listed below, do hereby authorize JUSTIN-SIENA HIGH SCHOOL and/or its agent(s) into whose care the minor has been entrusted, for the undersigned to consent to an X-ray examinations, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practice Act.

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 on the part of my (our) aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California and Section 1283 of the Health Code of California.

Student Name: _____ Birthdate: _____

Grade entering: _____ Gender M F

Name of Parent/Guardian: _____

Address: _____

_____ City _____ State _____ Zip _____ Phone # _____

EMERGENCY CONTACTS

Name of person/s to be contacted in case of sickness/accident *if parent not available:*

Name: _____ Home Number: _____

Cell Number: _____ Work number: _____

Name: _____ Home Number: _____

Cell Number: _____ Work number: _____

(Please Complete Reverse Side)

**EMERGENCY CONTACT AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR
CERTIFICATE OF HEALTH**

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**MINOR'S
MEDICAL
INSURANCE
INFORMATION**

Medical Insurance Carrier: _____

Policy #: _____ Group #: _____ Medical #: _____

Responsible Party: _____

Address: _____

City _____ State _____ Zip _____ Phone # _____

Employer: _____

TO BE FILLED OUT FOR 1st YEAR JUSTIN-SIENA STUDENTS ONLY
DATE OF EACH DOSE WAS GIVEN

	1 st	2 nd	3 rd	4 th	5 th	Booster
Polio (OPV or IPV)						
DTP/DTaP/DT/Td <small>(Diphtheria, tetanus and [acellular] pertussis OR tetanus and diphtheria only)</small>						
MMR (Measles, mumps, and rubella)						
Hepatitis B						
Varicella (Chickenpox)						
Hepatitis A (Not required)						

**VACCINE
INFORMATION**

**TO BE FILLED
OUT FOR 1st
YEAR JUSTIN-
SIENA
STUDENTS
ONLY**

TB test Negative Positive Date: _____
Month/Date/Year

Please describe any unusual physical or health related conditions below
(If none exist, please write/type in NONE):

Parent/Guardian Signature: _____ Date: _____

Students participating in Athletics will be required to have a Physical Examination. Forms are available in the Athletic Department Office.

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