CRISTO REY
NEWARK HIGH SCHOOL

The School That Works!

Emergency Contact Information
and Authorization for Emergency Medical/Surgical Treatment

 Academic Year: _____

I give permission for the school to provide, in an emergency, any medical assistance that my child/children might require. In the event that my child requires medical care (and determination thereof shall rest solely with the school), I hereby authorize the doctor and/or doctors and/or hospital to which he/she may be brought to take and perform all necessary procedures and render any indicated treatment, including the administration of anesthesia, if needed, and the performance of an operation, if in the opinion of said doctor or doctors the same is necessary, while he/she is under school jurisdiction. I agree to release, indemnify, and hold the school and its employees/agents harmless for any claims or liability for injury sustained by my child as a result of the permission granted herein.

Explanation: In emergency situations, where for any reason a parent cannot be reached immediately this form may be extremely important. The authorization will be used only when absolutely necessary only after every attempt has been made to reach the parents and/or designees. Time can be a factor when medical attention is needed, and this will assure that no time is lost in giving treatment.

Parent/Guardian Signature: _____ **Date:** _____

Name of student: _____ **Date of Birth:** _____ **Grade:** _____

Address: _____ **City:** _____ **Zip Code:** _____

Home Tel. #: (_____) _____ **Alternate home phone #:** (_____) _____

Parent/Guardian Name: _____ **Work #:** (_____) _____

Cell phone #: (_____) _____ **E-mail:** _____

Parent/Guardian Name: _____ **Work #:** (_____) _____

Cell phone #: (_____) _____ **E-mail:** _____

Emergency contacts (Designees): Two must be provided. We MUST have Emergency Contacts who are available AT ALL TIMES. Only these people can pick up your child from school unless a note or fax is sent.

Name: _____ **Relationship:** _____

Phone #: (_____) _____ **Cell #:** (_____) _____

Name: _____ **Relationship:** _____

Phone #: (_____) _____ **Cell #:** (_____) _____

Pages 1 & 2 MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN (over ➔)

Student: _____ **Grade:** _____

Medical History

List all allergies (food, medications, bee sting, etc.):

_____

_____

Is an Epi-Pen prescribed for any of these allergies? ☐ Yes ☐ No
* If yes, submit a *Food Allergy Plan*.

List all medical conditions (including asthma, diabetes, serious illness, operations, etc.):

_____

_____

* If your child has asthma, complete an *Asthma Action Plan*.

List all medications needed at home and in school:

_____

_____

* No medication will be administered in school unless a completed *Authorization to Administer Medication in School Form* is submitted.

Child's Physician: _____ **Phone #:** (_____) _____

Health Insurance Provider: _____ **Policy #:** _____

Do you give permission for the school nurse to contact your child's physician? ☐ Yes ☐ No

Parent Release for Medical Information

Cristo Rey Newark is required by federal law to preserve the privacy of your child's medical information. Access to student health records is limited to the School Nurse or administrative staff, and is only utilized for the safety of your child or in an emergency. By signing below you acknowledge that your child's medical information will be protected and will be released strictly on a need to know basis.

Parent/Guardian Signature: _____ **Date:** _____