Form 1

COURTYARD SCHOOL (2020)

In the event of a schoolwide emergency, it is important that we have the most complete information about how to contact you. Please complete this form with as much detail as you can and provide updates as contact information changes.

CHILD'S LAST NAME **FIRST** **INITIAL** **SEX** **DOB** **GRADE**

1ST PARENT CONTACT:

NAME HOME WORK

CELL EMAIL

HOME ADDRESS CITY ZIP

OCCUPATION EMPLOYER

2nd PARENT CONTACT:

NAME HOME WORK

CELL EMAIL

HOME ADDRESS CITY ZIP

OCCUPATION EMPLOYER

IN THE ABSENCE OF PARENT(S), CALL:

3RD CONTACT HOME WORK

CELL EMAIL

HOME ADDRESS

In the event of an emergency, I would like to be contacted as follows (please describe in detail):

PLEASE INDICATE ACTION DESIRED IN THE EVENT OF AN ACCIDENT OR EMERGENCY (CHECK BOX 1 OR 2)

1. ☐ In the event of an accident or other emergency, when a parent is unavailable, I hereby authorize a representative of the school to make such arrangements as he/she considers necessary for my child to receive medical or hospital care, including necessary transportation. Under such circumstances, I further authorize the physician named below to undertake such care and treatment of my child as he/she considers necessary. In the event said physician is not available at the time, I authorize such care and treatment to be performed by any licensed physician or surgeon.

PHYSICIAN NAME MEDICAL REC. NO. MILITARY I.D. NO.

PHYSICIAN ADDRESS PHYSICIAN PHONE

2. ☐ I do not choose the above statement and desire the following action

THE UNDERSIGNED HEREBY AGREES TO BEAR ALL COSTS INCURRED AS A RESULT OF THE FOREGOING.

X

PARENT'S SIGNATURE DATE

PLEASE CHECK HERE IF THERE ARE NO KNOWN HEALTH PROBLEMS ☐

Turn Over →

COURTYARD SCHOOL (2020)

PLEASE CHECK THE FOLLOWING ITEMS AS THEY PERTAIN TO YOUR CHILD:

	Yes	No	Comments
Known eye condition or defect in vision	_____	_____	_____
Wears glasses	_____	_____	_____
Wears contact lenses	_____	_____	_____
Known hearing problem	_____	_____	_____
Uses hearing aid	_____	_____	_____
Asthma	_____	_____	_____
Heart condition	_____	_____	_____
Fainting spells	_____	_____	_____
Epilepsy	_____	_____	_____
Hyperactive	_____	_____	_____
Diabetes	_____	_____	_____
Allergies (please specify)	_____	_____	_____
Has a physical condition which limits participation in activities	_____	_____	_____
Other (please specify)	_____	_____	_____
Taking prescribed medication	_____	_____	_____

***Medication Release Form must be completed if medications are to be given during school hours.**

FIELD TRIP PERMISSION

My son/daughter has permission to participate in Courtyard School's field trips. I understand that as a parent I am welcome to attend my child's field trips by giving Courtyard School prior notice of attendance and pay any necessary fees associated with the field trips. I understand that some field trips during the school year may have limited parent participation. I am aware that as part of the regular program of instruction at Courtyard, teachers often take students on short field trips to various sites within walking distance of the school. I understand that all transportation will be by walking, regional transportation, and chartered bus.

AUTHORIZATION TO CONSENT TO EMERGENCY TREATMENT OF MINOR

(I) (We), the undersigned, parent(s)/guardian(s) of the above a minor, do hereby authorize Courtyard School as agents for the undersigned in our absence, to consent to X-ray examination, anesthetic, medical or surgical diagnosis or treatment; hospital care which is deemed advisable by and is to be rendered under the general or special supervision and upon the advice of any physician and surgeon licensed under the Medicine Act, whether such diagnosis or treatment is rendered at the office of said physician or at any duly licensed medical facility.

It is understood this authorization is given in advance of any specific diagnosis, treatment, or hospital care required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent in any medical emergency to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of best judgment may deem advisable. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

X_____ _____

PARENT'S SIGNATURE DATE

AUTHORIZATION TO PICK UP CHILD

I hereby give standing permission for the following individuals to pick up my child. I understand that if persons other than the parent/guardian(s) will be picking up my child, I must call and give written or verbal authorization to the school. Children will not be released to individuals without permission from the parent/guardian.

Please list any custody information that the school should be aware of on a separate sheet of paper. Expanded Authorization forms are available if needed.

Please print clearly.

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that all the information above is correct and true. I understand that the school will be notified if any changes are to be made.

X_____ _____

PARENT'S SIGNATURE DATE