Inspire School of Arts and Sciences

Student's Name: LAST _______________________________ **First** _______________ **Grade** _____ **ID#** ____________

Birthdate: _______________ **Home Phone:** _________________

Mailing Address ____ **Apt/space** ____ **City** ____________ **Zip** ________

Parent Email Address ________________________ **Student Email Address** ____________________________________

Living with (please circle): mother/stepmother father/stepfather guardian (relationship): ____________________________

Father/guardian name: ____ Employer: _____________________________

Work phone: _______________________ cell/pager: _____________________ Work hours: ____________________

Mother/guardian name: ____ Employer: _____________________________

Work phone: _______________________ cell/pager: _____________________ Work hours: ____________________

If parent is not living with you: Parent name: ______________________________________ Phone: ________________

Address: ______________________________________ City _______________________ State _____ Zip _________

List persons(over 18) not living in the home that can come for or give permission for student to leave campus if parent unavailable.

1. Name: ___________________________________ Relationship ________________ daytime Phone _______________
2. Name: ___________________________________ Relationship ________________ daytime Phone _______________
3. Name: ___________________________________ Relationship ________________ daytime Phone _______________

Other children in family:

1. Name ___________________________ School _______________________ Grade _____
2. Name ___________________________ School _______________________ Grade _____

Date ____________________

AUTHORIZATION TO TREAT MINOR

I (We), the undersigned, parent, parents, or legal guardian of ________________________, a minor , do hereby authorized and consent to any X-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the 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 on the staff of any acute general hospital holding a current license to operate from the State of California Department of Public Health. 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 to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that nay of the above treatment will not be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of Section 25.8 of Civil Code of California.

LIST OF RESTRICTIONS ____

ALLERGIES TO DRUGS OR FOODS ____

LIST ANY SPECIAL MEDICATIONS OR ANY MEDICAL CONDITIONS ____

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Date of last TETANUS BOOSTER : ________________

IN CASE OF EMERGENCY AND PARENT OR GUARDAIN CANNOT BE REACHED, SCHOOL IS AUTHORIZED TO CALL:

LOCAL DOCTOR ________________________ **ADDRESS** ______________________ **PHONE** ________________
LOCAL DENTIST ________________________ **ADDRESS** ______________________ **PHONE** ________________
INSURANCE COMPANY ____ **POLICY #** ____________________

I declare under penalty of perjury that the foregoing is correct.

SIGNATURE OF: ____

Father (or) **Mother** (or) **legal guardian**