

Identification & Emergency Information

Academic Year 2011-2012



Please list the phone numbers you wish us to call FIRST in the event of an injury, illness, emergency, etc.

EMERGENCY PHONE: (____) ____ - _____ Parent Name _____ Relation _____

EMERGENCY PHONE: (____) ____ - _____ Parent Name _____ Relation _____

Student ID# _____ Campus student will be attending AH CT EW ME

Student's Legal Last Name		Student's Legal First Name & Middle Name		Grade Entering	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Home Street Address					Date of Birth	
City	State	Zip Code	Home Phone with Area Code			

Student Ethnicity: African American Arab Caucasian Chinese Filipino Hispanic Indian
 (Optional) Japanese Korean Pakistani Vietnamese Other: _____

Sibling's name _____ Campus sibling attends _____
 Sibling's name _____ Campus sibling attends _____
 Sibling's name _____ Campus sibling attends _____

Student lives at the address above with: Father Mother Stepfather Stepmother Guardian Other
 Student's parent(s) are: Married Separated Divorced Widowed Single

Father/Guardian Name Mr. Dr.

Mother/Guardian Name Mrs. Ms. Dr.

Check if home address is same as student's address

Check if home address is same as student's address

Home Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Cell _____
 Primary Email _____

Home Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Cell _____
 Primary Email _____

Father/Guardian Employer

Mother/Guardian Employer

Title _____
 Business Address _____
 City _____ State _____ Zip _____
 Work Phone _____

Title _____
 Business Address _____
 City _____ State _____ Zip _____
 Work Phone _____

DISASTER PREPAREDNESS - The Department of Social Services has requested that the following information be kept on file in the event of a disaster. Please give the school (and carry for yourself) a phone number for an out of state/area relative or friend. The school can communicate with this contact in the event that you, the parent or guardian, cannot be reached. Out of state/area adult to be contacted:

Name	Address	Relationship	Telephone
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A second name may be designated (optional). Second out of state/area adult to be contacted:

Name	Address	Relationship	Telephone
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Last Name:

First Name:

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Additional persons who may be called in an emergency

Name	Address	Relationship	Telephone
Name	Address	Relationship	Telephone

Authorized persons to take child from facility or extended day care

Name	Address	Relationship	Telephone
Name	Address	Relationship	Telephone

Person NOT authorized to take child from facility or extended day care

Name	Address	Relationship	Telephone
Name	Address	Relationship	Telephone

AUTHORIZATION FOR TREATMENT OF A MINOR - EMERGENCY INFORMATION

Physician's Name	City	Telephone	Fax
Dentist's Name	City	Telephone	Fax
Insurance Carrier	Policy #	ID #	

Specific information (allergies, medications, medical problems, etc.):

Any disability we should be aware of:

I (We), the undersigned parent(s)/guardian(s) of _____ a minor, do hereby authorize FPS, its adult agents and employees, into whose care said minor has been entrusted, while traveling to and from school, while attending FPS and field trips and outings sponsored by FPS, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to said minor under the general or special supervision and upon advice of a physician and/or surgeon licensed under the provisions of the Medical Practice Act, or to consent to any X-ray examination, anesthetic, dental or surgical diagnosis or treatment to be rendered to said minor by a dentist licensed under the provision of the Dental Practice Act. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required and it is given to provide authority and power on the part of FPS, its adult agents and employees to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician or dentist in the exercise of his or her best judgment may deem advisable. The authorization is given pursuant to the provision of Section 25.8 of the Civil Code of California. I (We) agree to pay all medical expenses for my son/daughter not covered by insurance.

Notice of Address Change: If you move, you must submit a notice within 10 days of the change of address to your school official.

FIELD TRIPS: I (We) consent for my (our) child to take supervised field trips and further agree to hold harmless FPS for any action not caused by a deliberate or negligent act for injuries to my (our) child. Individual forms may also be required for each field trip.

SIGNATURE REQUIRED

The undersigned is/are a person(s) having legal custody of, or is/are the legal guardian(s) of said minor and acknowledges the above information is correct and complete; and that my (our) email address(es) may receive periodic Fairmont communications.

Both signatures are required (if applicable):

Mother/Guardian's signature

Date

Father/Guardian's signature

Date