

**VIKINGS KINGDOM ~ EXTENDED CARE PROGRAM
DIOCESE OF ORANGE
2011-2012 EMERGENCY INFORMATION
OUR LADY OF GUADALUPE SCHOOL**

FAMILY INFORMATION

LAST NAME	TELEPHONE (HOME) ()	E-MAIL FOR DAYTIME UPDATES
ADDRESS (HOME)	CITY	ZIP
FATHER'S NAME	CELL PHONE (FATHER) ()	WORK HOURS
FATHER'S EMPLOYER	WISH TO CALL AT WORK CIRCLE ONE YES or NO	
ADDRESS (FATHER'S WORK)	(WORK) PHONE ()	
MOTHER'S NAME	CELL PHONE (MOTHER) ()	WORK HOURS
MOTHER'S EMPLOYER	WISH TO CALL AT WORK CIRCLE ONE YES or NO	
ADDRESS (MOTHER'S WORK)	(WORK) PHONE ()	

STUDENT INFORMATION

FIRST NAME	LAST NAME	BIRTHDATE	GRADE	PRECAUTIONS
		MO DAY YR / /		
		MO DAY YR / /		
		MO DAY YR / /		
		MO DAY YR / /		

Child (ren) live with: _____ Mother _____ Father _____ Both Parents _____ Other _____ Grandparents

I authorize Our Lady of Guadalupe School extended care program staff to release my above named child(ren) to the adults listed below in the event I am unable to pick them up on any given day. **(Please list in order of preference)**

I understand that any of these adults may be required to show proper identification and at that time my child(ren) is/are signed out of the program. Our Lady of Guadalupe School and extended care staff relinquishes all responsibility for my child(ren).

I also understand that my child(ren) will not be released for any reason, to any person not on this form. Unless I submit a signed, dated and written authorization note. **(phone call to release students will not be accepted)**

1. Name: _____ Best Phone No.: _____
Relationship: _____ Driver's License #: _____
2. Name: _____ Best Phone No.: _____
Relationship: _____ Driver's License #: _____
3. Name: _____ **Best Phone No.:** _____
Relationship: _____ Driver's License #: _____
4. Name: _____ Best Phone No.: _____
Relationship: _____ Driver's License #: _____

FAMILY NAME _____

We the undersigned parent(s) of _____ a minor(s), do hereby authorize a representative of the Our Lady of Guadalupe Extended Care Program presenting this form to call a physician and to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable for our child(ren). (Also including dental diagnosis and/or treatment). It is understood that a conscientious effort must be made to notify me before any such action is taken. It is further understood that we release Our Lady of Guadalupe and/or the person representing this form of all liabilities connected with the transportation, diagnosis treatment, hospital care and expenses necessary for the treatment for our child(ren). This authorization is given pursuant to the provision of Section 25.8 of the Civil Code of California.

STUDENT INFORMATION:

<u>Student's Name</u>	<u>Grade</u>	<u>Birthdate</u>	<u>Allergies & Precautions</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Physician's Name: _____ Phone #: _____

Address: _____ City: _____

Hospital Preference: _____ City: _____

Insurance Carrier: _____ Policy #: _____

Dentist's Name: _____ Phone #: _____

Insurance Carrier: _____ Policy #: _____

HEALTH PROBLEMS AND/OR SPECIAL INSTRUCTIONS:

PARENT'S SIGNATURE: _____ DATE: _____

PARENT'S SIGNATURE: _____ DATE: _____

Please complete BOTH sides.