

2012-13 Authorization to Treat/Emergency Contact and Handbook Agreement

Grade _____

STUDENT: (as it appears on Birth Certificate)

LAST Name _____ FIRST Name _____ MIDDLE Name _____

SSN _____ - _____ - _____ Date of Birth _____

EMERGENCY CONTACTS (other than parent):

Contact # 1 _____ Relationship _____ H Phone _____ W Phone _____ C Phone _____

Contact # 2 _____ Relationship _____ H Phone _____ W Phone _____ C Phone _____

Legal Alert: _____

EMERGENCY STUDENT RELEASE

In the event of an emergency in which it is necessary for my son to be released from Holy Cross School, I hereby authorize Holy Cross School to permit him to exercise the option(s) below. I understand that the responsibility of the school for the safety of my son terminates immediately upon his exercising the option. I hereby absolve Holy Cross School and/or its administrators from any liability or claim, of any nature whatsoever, for anything arising out of, or resulting directly or indirectly from, his exercise of such options. *Please place your signature by those options which you wish to exercise.*

(Signature)

- 1) Permit my son to take his usual Holy Cross School bus route at the time of dismissal. _____
- 2) Permit my son to leave school with his carpool. _____
List carpool student/parent members: _____
- 3) Permit my son to leave campus using his own vehicle. _____
- 4) Permit my son to leave campus with the persons as follows (in addition to those listed above): _____

- 5) Permit my son, who is not a regular bus rider, to leave campus on a Holy Cross School bus. _____
- 6) Permit my son to leave only with his parent or guardian. _____

MEDICAL INFORMATION

Emergency Medical Physician (1) _____ Phone _____

Emergency Medical Physician (2) _____ Phone _____

Allergies to medicine or insect bites: Yes _____ No _____

Please explain if "Yes": _____

Presently takes medication: Yes _____ No _____

Please explain if "Yes": _____

Students that drive: Do you want your son to drive himself home should he become ill at school? Yes _____ No _____

AUTHORIZATION TO TREAT A MINOR

I (we) authorize and consent to my son, a minor, receiving any x-ray examination, anesthetic, medical or surgical diagnosis or treatment supervision upon the advice of a licensed physician. It is understood that reasonable effort shall be made to contact the undersigned prior to rendering treatment, but that treatment will not be withheld if the undersigned cannot be reached.

Signature of Mother/Guardian: _____ Date _____ Cell Phone _____

Signature of Father/Guardian: _____ Date _____ Cell Phone _____

HANDBOOK AGREEMENT

We have read the Holy Cross Student-Parent Handbook and agree to abide by all school policies and regulations.

Signature of Student: _____ Date _____

Signature of Mother/Guardian: _____ Date _____

Signature of Father/Guardian: _____ Date _____