



# EMERGENCY MEDICAL INFORMATION

I hereby give consent to perform medical or dental treatment on my (son/daughter) in case of an emergency. I understand that SRO does not assume responsibility for payment of a physician in any case. However, in an emergency SRO may choose a physician. Please state: Yes \_\_\_\_\_ No \_\_\_\_\_

Name (son/daughter): \_\_\_\_\_ School Attending: \_\_\_\_\_

Student Home Address: \_\_\_\_\_

Student Home #: \_\_\_\_\_ Student Cell #: \_\_\_\_\_

Student Birthdate: \_\_\_\_\_ Student Email: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Name of Relative: \_\_\_\_\_ Phone#: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_

Name of Dentist: \_\_\_\_\_ Phone#: \_\_\_\_\_

Medical Insurance Co. Group: \_\_\_\_\_ Coverage#: \_\_\_\_\_

My son/daughter is allergic to the following medication(s):

\_\_\_\_\_  
\_\_\_\_\_

My son/daughter has the following special health needs:

\_\_\_\_\_  
\_\_\_\_\_

My son/daughter has asthma: Yes \_\_\_\_\_ No \_\_\_\_\_

My son/daughter is able to manage their asthma with the use of \_\_\_\_\_

and \_\_\_\_\_ IS / \_\_\_\_\_ IS NOT allowed to participate with Students Run Oakland.

## CONSENT FOR TREATMENT

(We), the undersigned parents(s) or legal guardian of \_\_\_\_\_ a minor, do hereby authorize a representative of Students Run Oakland as agent(s) for the undersigned to consent to x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care that is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the California Medicine Practice Act, on the medical staff of an accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. 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 on the part of the above-mentioned agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care that the above mentioned physician in the exercise of his or her judgment may deem advisable. This authorization shall remain effective until March 30, 2010 unless sooner revoked in writing and delivered to the above-mentioned agent(s).

Parent/Legal Guardian Name (Print): \_\_\_\_\_

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_