2016-17 Authorization to Treat/Emergency Contact and Handbook Agreement
Primary School 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 (Please forward legal documentation): _____

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 leave school with his carpool. _____
   List carpool student/parent members: _____
   _____

2) Permit my son to leave campus with the persons as follows (in addition to those listed above): _____
   List Names: _____
3) Permit my son to leave only with his parent or guardian. _____

MEDICAL INFORMATION

Emergency Medical Physician (1) _____ Phone _____
Emergency Medical Physician (2) _____ Phone _____
Emergency Dental Physician _____ Phone _____

Allergies to medicine, food or insect bites: Yes __ No _____
Please explain if "Yes": _____
_____

Presently takes medication: Yes _____ No _____
Please explain if "Yes": _____
_____

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 _____