TEMPLE CITY HIGH SCHOOL
EMERGENCY FORM--PERFORMING ARTS

Name_____Date of Birth_____

Address_____City_____Zip_____

I am a Chaperone_____--or-- Student_____ Grade_____ Age_____

School or Group Name_____Date of Program_____

Phone #_____ Cell #_____

Do you have any severe medical problems? Such as:
(asthma, allergy to drugs, heart trouble, epilepsy, diabetes, physical handicaps, dietary restrictions?) Yes No

If yes, specify:

Are you taking any medications? Yes No

If yes, specify:

Should there be any limits on your physical activity? Yes No

If yes, specify:

Have you had any serious illness in the last three years? Yes No

If yes, specify:

At the present time, are you under doctor's care? Yes No

If yes, specify:

Are you allergic to insect stings? (i.e., wasp, bee, etc.) Yes No

If yes, specify:

(If yes, counteractive medications must be carried at all times)

In case of an emergency, may a medical clinic contact your doctor for records?
Yes No

Doctor's Name_____Phone ( )_____

Address_____City_____Zip_____

Are you covered by medical insurance? Yes_____ No_____

Company Name_____Card #_____

Date of last complete physical exam_____Last Tetanus Toxoid injection_____

In addition to your parents or guardians, what two relatives, neighbors or friends may be called in case of emergency? Please list two persons, including relationship to you and telephone number:

Name / Relationship Phone #

_____( )_____

_____( )_____

(COMPLETE REVERSE SIDE)

If you are below the legal age of consent (18 years) the law requires that we have your parent's permission to give medical service should the need arise. Please complete the following:

Medical Permission

The Undersigned, who is one of the parents having legal custody, or the legal guardian, of the student named above, a minor, hereby authorizes the adult chaperone of other personnel of the Temple City Unified School District into whose care said minor has been entrusted, 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 on the advice of a physician and surgeon licensed under the provisions of the Medical Practice Act, or to consent to an X-ray examination, anesthetic, dental or surgical diagnosis, or treatment and hospital care to be rendered to said minor by a dentist licensed under the provisions of the Dental Practice Act.

For minor illnesses or injuries, the Temple City Unified School District will attempt to contact me before my son/daughter leaves the medical office. For major illnesses or injuries, the Temple City Unified School District will attempt to contact me before institution of treatment, unless such treatment is so urgent it must be done before contact can be made. If I cannot be reached, this authorization nevertheless is effective. I also agree to assume any financial responsibility for my son/daughter's care.

This consent shall be in effect from_____to_____, 20____

It is hereby agreed that the Temple City Unified School District shall not be held responsible for any injuries that might occur to the applicant(s) at any time or at any place.

Parent/Guardian Signature_____Date_____

Printed signature_____

Parent/Guardian's Telephone- Home ( )_____

Work ( )_____

Cell ( )_____

(10/09)