Enrollment/Emergency Release Form

Student's Full Name _____

Address _____ City _____ State_____ Zip_____

High School _____ Grade Level_____

Birthdate _____

Female____ | Male _____

Student is living with: ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian

Primary language spoken in our home_____

Parent/Legal Guardian Full Name_____

Birthdate_____ Email_____

Address_____City_____ State_____ Zip_____

Place of Employment_____

Work #_____ Cell Number_____ Driver License #_____

Parent/Legal Guardian Full Name_____

Birthdate_____ Email_____

Address_____City_____ State_____ Zip_____

Place of Employment_____

Work #_____ Cell Number_____ Driver License #_____

Please list additional persons to call in case of emergency and persons authorized to take student from Omnitrans (must include three persons with different phone numbers.)

1. Full Name_____ Cell_____ Relationship_____

2. Full Name_____ Cell_____ Relationship_____

3. Full Name_____ Cell_____ Relationship_____

An Authorization to Consent To Treatment of Minor

We, the undersigned parent(s)/guardian of _____ hereby authorize any physician on the staff of a Licensed Hospital or Emergency Clinic, or any other physician designated by him (them) as agent(s), for the undersigned, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician or surgeon on the staff of a Licensed Hospital or Emergency Clinic, whether such diagnosis or emergency treatment is rendered at the Office of said Physician or at said hospital(s). It is understood that this authorization is given in advance of any special consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician(s), in the exercise of his (their) best judgment, may deem advisable. This authorization is given pursuant to the provision of Section 25.A of the Civil Code of California.

Family Physician_____

Physician Address_____ City_____ State_____ Zip_____

Physician Telephone #_____

Medications, allergies, serious medical issues_____

Signature of Parent/Legal Guardian_____ Date_____