Paradise e learning Academy
STUDENT HEALTH AND EMERGENCY INFORMATION UPDATE

Grade _____ School Year _2018-2019_

Please complete and return to the Paradise e learning Academy

❑ Check here if any of the following information is new or different (address, phone, emergency contact, new health condition, etc.)

Student's Name | Date of Birth | Home Phone

Residence and Mailing Address | City | Zip Code

Father/Guardian_____ Work Phone_____ Cell Phone_____
Mother/Guardian_____ Work Phone_____ Cell Phone_____
Student Cell Phone_____

Please list any emergency contacts in case parents cannot be reached:

Name:	Contact Number(s)	Relationship to Student
1.		
2.		
3.		
4.		

*****If any of the above information changes, please notify the health secretary at 872-6425 ext. 3002*****

List school age siblings:

Name	School Attending	Grade Level
1.		
2.		
3.		

----------10th Grade Parents Only----------

Vision and hearing testing is done for all **10th graders**.
If you ***do not*** want your student tested**,** sign below.

READ BEFORE SIGNING

I object to my child (print name) _____receiving a hearing and/or vision test.

Parent signature_____ Date: _____

*****Please complete the other side*****

Paradise High School
HEALTH UPDATE

List any known medical conditions or health problems for this student:

_____

_____

_____

List any known allergies for this student: _____

_____

Are any of these allergies severe or life threatening, or do they require immediate treatment?

- ❑ No
- ❑ Yes. Explain: _____

_____

Does this allergic reaction require that an emergency injection be given if it occurs?

- ❑ No
- ❑ Yes. Explain: _____

_____

Doctor: _____ Phone: _____

AUTHORIZATION FOR TREATMENT OF MINOR

(I/We), the undersigned, parent(s)/guardian(s) of _____,
Print student name in full

a minor, do hereby authorize Paradise Unified School District as agent 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 to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of any 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 our aforesaid agent to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization shall remain effective until revoked in writing and delivered to said agent.

_____ Date: _____ Phone: _____
Signature of father/legal guardian

_____ Date: _____ Phone: _____
Signature of mother/legal guardian