

**FRENCH AMERICAN INTERNATIONAL SCHOOL - INTERNATIONAL HIGH SCHOOL  
LYCÉE INTERNATIONAL FRANCO-AMÉRICAIN**

**EMERGENCY HEALTH CARD**

*Completion of this form is required annually and must be submitted prior to the first day of school.*

<b>STUDENT:</b>	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	DATE OF BIRTH:	<b>GRADE/CLASS</b>
<b>SIBLING NAME(S)/GRADE:</b>			
<b>PARENT:</b>	ADDRESS:	Home Tel.:	Cellular: Email address
<b>EMPLOYER:</b>	ADDRESS:	Work Tel.:	Email address:
<b>PARENT:</b>	ADDRESS:	Home Tel.:	Cellular: Email address:
<b>EMPLOYER:</b>	ADDRESS:	Work Tel.:	Email address:
<b>DOCTOR:</b>	ADDRESS:	PHONE:	
<b>DENTIST:</b>	ADDRESS:	PHONE:	
<b>INSURANCE:</b>	ID NUMBER:	PHONE:	
<b>EMERGENCY CONTACT:</b>	RELATION TO STUDENT:	DAY PHONE:	EVE PHONE:
<b>EMERGENCY CONTACT:</b>	RELATION TO STUDENT:	DAY PHONE:	EVE PHONE:
<b>OUT OF STATE CONTACT:</b>			
LAST NAME		FIRST NAME	
PHONE:		PHONE:	
HOW MANY CHILDREN WOULD YOU HOST IN YOUR HOME IN CASE OF A NATURAL DISASTER? BOYS: _____ GIRLS: _____ EITHER: _____			
IF ARRANGEMENTS HAVE ALREADY BEEN MADE WITH A SCHOOL FAMILY, PLEASE INDICATE THE NAMES OF THE CHILDREN YOU WILL HOST:			
<b>MEDICAL HISTORY: CHECK ALL THAT APPLY</b>			
<input type="checkbox"/> ASTHMA <input type="checkbox"/> DIABETES <input type="checkbox"/> MIGRAINE HEADACHES <input type="checkbox"/> ALLERGY TO BEE STINGS <input type="checkbox"/> DRUG ALLERGY: _____ <input type="checkbox"/> FOOD ALLERGY: _____ <input type="checkbox"/> CHRONIC CONDITION: _____ <input type="checkbox"/> MEDICATIONS PRESCRIBED: _____			
<b>I HEREBY AUTHORIZE THE SCHOOL TO GIVE MY CHILD TYLENOL OR IBUPROFEN FOR PAIN REMEDY, INJURY OF FEVER:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR</b>			
<p>WE HEREBY AUTHORIZE A SCHOOL REPRESENTATIVE, OR SUCH SUBSTITUTE AS MAY BE DESIGNATED FROM TIME TO TIME AS OUR AGENT(S), TO CONSENT TO ANY ANESTHETIC, HOSPITAL CARE, X-RAY EXAMINATIONS, MEDICAL, OR SURGICAL DIAGNOSIS OR TREATMENT WHICH IS DEEMED ADVISABLE BY, AND IS TO BE RENDERED UNDER THE GENERAL OR SPECIAL SUPERVISION OF A PHYSICIAN OR SURGEON LICENSED UNDER THE PROVISIONS OF THE MEDICAL PRACTICE ACT, OR DENTIST LICENSED UNDER THE PROVISIONS OF THE DENTAL PRACTICE ACT, WHETHER SUCH DIAGNOSIS OR TREATMENT IS RENDERED AT THE OFFICE OF SAID PHYSICIAN, DENTIST, HOSPITAL, OR OTHERWISE.</p> <p>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 SAID AGENT(S) TO GIVE SPECIFIC CONSENT TO ANY AND ALL SUCH DIAGNOSIS, TREATMENT OR HOSPITAL CARE WHICH SUCH PHYSICIAN OR DENTIST, IN THE EXERCISE OF THEIR BEST JUDGEMENT, MAY DEEM ADVISABLE. THIS AUTHORIZATION IS GIVEN PURSUANT TO THE PROVISIONS OF SECTION 25.8 OF THE CIVIL CODE OF CALIFORNIA AND SHALL REMAIN EFFECTIVE UNTIL REVOKED.</p>			
<input type="checkbox"/> <b>IN THIS CONNECTION I/WE HEREBY INCORPORATE BY REFERENCE THE "AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR" AS SET FORTH ABOVE.</b>			
<input type="checkbox"/> <b>IN THIS CONNECTION I/WE HEREBY INCORPORATE BY REFERENCE THE "AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR WITH THE FOLLOWING EXCEPTION(S):</b>			
<input type="checkbox"/> <b>I/WE EXPRESSLY WITHHOLD SUCH AUTHORIZATION.</b>			
I/WE HEREBY AUTHORIZE THE FRENCH AMERICAN INTERNATIONAL SCHOOL TO ENGAGE FOR MY/OUR CHILD, AT MY/OUR EXPENSE, ANY NECESSARY EMERGENCY MEDICAL OR DENTAL CARE UNTIL I/WE CAN BE INFORMED AND CAN MAKE FURTHER ARRANGEMENTS.			
SIGNED:		DATE:	

Please check here if you have moved or changed telephone number(s).



## FRENCH AMERICAN INTERNATIONAL SCHOOL - INTERNATIONAL HIGH SCHOOL

Health Center: 415-558-2003

Dear Families,

The Emergency Health Card on the reverse side is our best resource for contacting you during the time your child is at school. **Please complete all sections of the form including your cell, work and home phone numbers along with your email addresses.**

On occasion, we have students who become ill or are injured at school and require immediate medical assistance. When a student requires **immediate medical assistance**, our protocol is to call 911 first and then contact the parents or guardians. In an emergency, if we are unable to reach the parents or guardians, a staff member from school will accompany the student and the paramedics to an emergency room and stay with the child until the parent or guardian arrives.

In the absence of parents or guardians, the medical history section of the Emergency Health Card (see reverse side) is important to those who will transport and treat your child. **Therefore, we ask that you give us as much medical information as you can, particularly if your child has a chronic medical condition or history of drug allergies. Additionally, please list all medications that your child takes regularly.**

We urge parents or guardians of students who take medication for a chronic disease to bring a three day supply of their medication to the Health Center to be used in the event of a major earthquake or other civil disaster. If such a disaster were to occur, students might not be able to travel to their home for a significant amount of time.

Thank you for your assistance

Gail Kay, Health Aide, [gailk@frenchamericansf.org](mailto:gailk@frenchamericansf.org)

### LYCÉE INTERNATIONAL FRANCO-AMÉRICAIN

**Infirmierie : 415-558-2003**

Chères Familles,

La fiche de renseignements au verso est le document essentiel qui nous permet de vous contacter en cas d'urgence pendant les activités scolaires et périscolaires. **Nous vous remercions de prendre le temps de la lire avec attention et de bien vouloir répondre à toutes les questions. N'oubliez pas de nous indiquer vos numéros de « pager », de téléphones portables, personnels et professionnels ainsi que vos adresses électroniques.**

Il arrive qu'un enfant tombe malade ou ait besoin **d'assistance médicale immédiate**. Dans cette éventualité, nous appelons le 911 puis les titulaires de l'autorité parentale. En cas d'urgence et dans l'éventualité où nous *n'arriverions pas à vous joindre*, un membre du personnel ou moi-même se joindra à l'équipe para-médicale pour accompagner l'enfant aux urgences et lui tiendra compagnie jusqu'à l'arrivée d'un membre de sa famille.

En cas d'absence des titulaires de l'autorité parentale, le bilan médical que nous vous demandons de compléter sur la fiche d'informations (voir au verso) est primordial pour ceux qui prennent en charge votre enfant. **C'est pourquoi nous nous permettons de vous demander de nous communiquer l'historique médical le plus complet possible en précisant toute allergie, prescription médicale ou maladie chronique. Nous vous remercions de bien vouloir ajouter la liste éventuelle de médicaments que votre enfant prendrait de manière suivie.**

Si votre enfant est sous traitement pour cause de maladie chronique, nous vous demandons de bien vouloir apporter une dose de médicaments équivalente à deux jours de traitement en cas de tremblement de terre ou autre catastrophe. En effet, votre enfant ne pourrait probablement pas rentrer chez lui en de telles circonstances, avant un certain laps de temps.

Nous vous remercions de votre compréhension et de votre coopération.

Gail Kay, Aide Soignante, [gailk@frenchamericansf.org](mailto:gailk@frenchamericansf.org)