

PLEASE COMPLETE ONE FORM FOR EACH CHILD.  
PLEASE COMPLETE ENTIRE FORM-FILL IN ALL BLANKS  
EMERGENCY CARE AND CONSENT FORM  
St. John's Lutheran School, Summer Camp, Dance Camp/Team & PALS  
3521 Linda Vista Ave. Napa, CA 707-226-7970

CHILD'S NAME \_\_\_\_\_ Grade \_\_\_\_\_ HOME # \_\_\_\_\_ - \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ CITY & ZIP \_\_\_\_\_

BIRTHDATE \_\_\_/\_\_\_/\_\_\_ MOM'S CELL # \_\_\_\_\_ - \_\_\_\_\_ DAD'S CELL # \_\_\_\_\_ - \_\_\_\_\_

EMAIL ADDRESS!! \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_ - \_\_\_\_\_

CHOICE OF HOSPITAL \_\_\_\_\_ PHONE \_\_\_\_\_ - \_\_\_\_\_

CHILD LIVES WITH: BOTH PARENTS \_\_\_\_\_ MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_

FATHER'S NAME (GUARDIAN) \_\_\_\_\_ MOTHER'S NAME (GUARDIAN) \_\_\_\_\_

\*Church attending (put none if not attending a church) \_\_\_\_\_  
Attending \_\_\_\_\_ Member \_\_\_\_\_ Pastor's Name \_\_\_\_\_

\*Race/Ethnicity \_\_\_\_\_

(Dad's) EMPLOYER'S NAME/OCCUPATION & PHONE # \_\_\_\_\_

(Mom's) EMPLOYER'S NAME/OCCUPATION & PHONE # \_\_\_\_\_

Any other pertinent information needed: (medications taken, allergic reactions, etc):  
\_\_\_\_\_

OTHER EMERGENCY CONTACTS

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

IN ADDITION I AUTHORIZE THESE PERSON(S) TO PICK-UP MY CHILD FROM SCHOOL OR PALS:

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\*\*\*\*\*St John's Lutheran school (has permission/does not have permission) (circle one) to utilize my child's photo as part of a public display for the purposes of public relations for the school.

In the event I cannot pick-up my child from school, he / she is authorized to go to PALS. I hereby authorize members of the faculty/staff of St. John's Lutheran School of Napa to consent to any x-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care for the above named minor, which is deemed advisable by, licensed under the Provision of Medicine Practice Act, or of any dentist, licensed under Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, or elsewhere.

This authorization will remain effective while the above minor is enrolled at St. John's Lutheran School or involved or participating in any activity sponsored by the school.

PARENT / GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_

HEALTH INSURANCE \_\_\_\_\_ POLICY / GROUP # \_\_\_\_\_