St. Paul Church
Littlest Angel Preparatory Preschool/PreK
221 Valley Street, Room X
San Francisco, CA 94131-2320
Phone: (415) 824-5437 Cell Phone: (415) 517-3635
e-mail address: littlestangelpreschool@gmail.com

Child's Name: _____Home Phone: _____

Birthdate: _____ Work Phone: F-_____ Work: M:_____

Address: _____ City: _____ Zip:_____
Parent/Guardian's Name: _____
(Please Print)

Address-Work: F:_____City:_____Zip:_____
Address-Work: M:_____City:_____Zip:_____

Person(s) Other Than Parent To Notify in Case of Emergency:

Name: _____Address:_____Phone:_____
(Please Print) (Please Print)
Name: _____Address:_____Phone:_____
(Please Print) (Please Print)

I, the parent (guardian) of _____, hereby give my permission for his/her participation in all activities for the current school year provided:

I receive a detailed description of these activities (including time, place and mode of transportation)

I agree to direct my child to cooperate with the directions and instructions the parish, school or Archdiocesan personnel responsible for the activity.

I agree that in the event my child is injured as a result of hi/her participation in any of these activities, including transportation to and from the activity, whether or not caused by the negligence (active or passive) of parish/school or Archdiocesan youth activities program, or any of its agents/employees, recourse for the payment of any resulting hospital, medical or related costs and expenses will first be had against any accident, hospital or medical insurance, or any available benefit plan of mine or of my spouse.

I am not aware of any medical condition of my child which would render it inappropriate for him/her to participate in any such activities.

I, hereby, give permission to the physician selected by the parish, school or Archdiocesan personnel then present to render medical treatment deemed necessary and appropriate by the physician.

Parent/Guardian's Signature:_____Date: _____
Parent/Guardian's Signature:_____Date: _____
*****While being sensitive to single parent situations – signatures of both parents should be obtained when possible.

(over)

Authorization for Treatment

I, the undersigned, parent or guardian of _____ a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical treatment rendered by any Member of the medical or emergency department staff licensed under the provisions of the Medicine Practice Act, a Dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care deemed advisable by the aforementioned physician in the exercise of his best judgment. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that none of the above treatment will be withheld if the undersigned cannot be reached.

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

_____ _____

Signature of Father, Mother or Legal Guardian Date

_____ _____

Signature of Father, Mother or Legal Guardian Date

MY CHILD IS ALLERGIC TO AND/OR HAS THE FOLLOWING MEDICAL CONDITION: