San Bernardino Valley College

Confidential Youth Emergency Card

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Parent or guardian, please print in ink the requested information below:

Last Name: ______________________________ First Name: ______________________________

Date of Birth: ____________ Student I.D. #: ______________ Home Phone: ______________

Street Address: _________________________ City: __________________________ Zip:________

______________________	______________	______________	___________
Father's/Guardian Name	Phone #	Work #	Cell Phone #
Mother's/Guardian Name	Phone #	Work #	Cell Phone #

A local contact person in case of illness or injury if parent/guardian cannot be reached:

Name: ____________________ Relationship: ______________ Phone #: ______________

Physician's Name:______________________ Phone #___________

Medical Insurance:____________________Subscriber #___________

Please list any medical conditions we should know about in an emergency.

____

Are there medications the student takes regularly? __No __Yes Please List:

____

Does the student have any allergies to medications or other substances?
Please List:____

Students seeking emergency care, birth control, pregnancy testing, or STD/ HIV screening and care are considered by law to be *mature minors* with the right to consent for these specific medical services.

I, the undersigned parent/guardian of ________________________________, hereby authorize the Medical and counseling staff of San Bernardino Valley College (SBVC) Student Health, as agent of the undersigned to consent to any diagnostic procedure (including x-rays), to the administration of any counseling, medical, surgical treatment, or to any accredited hospital when any or all of the foregoing is deemed advisable and is to be rendered under the general Supervision of any Physician or surgeon licensed under the provisions of the Medical Practice Act.

I ___DO ___ DO NOT grant the staff of the SBVC student health permission to give the above named student over the counter medication for symptom relief if they are unable to reach me for verbal consent.

This authorization is given in advance of any specific diagnosis, treatment or medical care being required and pursuant to the provisions of Section 25.9 of the California Civil Code.
It shall remain in effect throughout the term designated on this form.

X____ Date: ______________