City of Fresno P.A.R.C.S Department

Participant Emergency Information

Participant's Name:_____ Birthdate:_____ Male____ Female_____

Home Address:_____ City:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Email Address:_____

IN CASE OF ILLNESS OR ACCIDENT CONTACT:

1. Name of Mother:_____ Home Phone:_____ Email Address:_____
   Place of Employment:_____ Work Phone:_____ Cell Phone:_____
2. Name of Father:_____ Home Phone:_____ Email Address:_____
   Place of Employment:_____ Work Phone:_____ Cell Phone:_____
3. Name of Guardian:_____ Home Phone:_____ Email Address:_____
   Place of Employment:_____ Work Phone:_____ Cell Phone:_____
4. Additional Contact:_____ Relationship_____ Phone:_____
5. Additional Contact:_____ Relationship_____ Phone:_____

If an emergency should arise which requires immediate medical attention and we, as parents/guardians cannot be contacted, you are authorized to take whatever steps are needed to protect the health of this child. ____Yes ____No

I understand that if any emergency medical or dental treatment is needed and the listed emergency contacts cannot be reached, 911 will be called. I realize the City of Fresno cannot assume responsibility for the payment of medical fees or expenses incurred, including the cost of emergency transportation. I understand and agree that the City of Fresno and its officers, officials, employees, agents, and volunteers assume no liability of any nature in relation to the emergency transportation of my child. I also agree that the supervisor/designee may transport my child between City property and home when, in his/her discretion, it is deemed necessary. **Parent/Guardian Signature:_____ Date:_____**

MEDICAL INFORMATION

My child has the following health condition (s) that may affect him / her on trips. Please check all that apply to this participant.

___ Vision: glasses/contacts ___ Heart condition ___Cancer ___Leukemia Blood Type:_____

___ Hearing: loss/aid ___ Asthma ___ Diabetes ___ Seizures

___ Food allergies: List_____

___ Other allergies: List_____

___ Other health conditions, please explain: _____

_____

_____

Family Doctor/Clinic: _____ Health Insurance Plan: _____

List other relatives attending this program.

1._____

2._____

3._____

4._____

The parent/guardian of any participant on a continuing medication regimen shall inform the point person or supervisor/ designee of the medication behind taken, dosage, time schedule, and name of prescribing physician. If medication is necessary, a written statement from a physician and parent authorization (signature) is required.

Name of Medication: _____ Dosage: _____

Name of Prescribing Physician: _____ Phone #: _____

Additional Notes:_____

_____

_____