

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. _____
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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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_