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: ______________________________________

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____

Family Doctor/Clinic: ______________________ Health Insurance Plan: _______________

List other relatives attending this trip:

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:____

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