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www.prrcsf.org

EMERGENCY INFORMATION / AUTHORIZATION FORM

For the safety of your child, please fill out the form **completely**.

FAMILY INFORMATION

Child's Name: _____ Birthdate: ____/____/____
Address: _____ City: _____ Zip: _____

Mother's / Guardian's Information

Father's / Guardian's Information

Name: _____ Name: _____
Work Phone: (____) _____ Work Phone: (____) _____
Home Phone: (____) _____ Home Phone: (____) _____
Cell Phone: (____) _____ Cell Phone: (____) _____
Email: _____ Email: _____

EMERGENCY CONTACT(S)

Names of persons to be called in case of emergency if parents / guardians cannot be reached.
(MUST BE **DIFFERENT** FROM MOTHER & FATHER NAMED ABOVE).

Name:	Phone:	Relation:	Name:	Phone:	Relation:
1. _____	(____) _____	_____	2. _____	(____) _____	_____
3. _____	(____) _____	_____	4. _____	(____) _____	_____

Names of person(s) **authorized** to pickup child from the Pomeroy Recreation & Rehabilitation Center:

Name:	Relation:	Name:	Relation:
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

PHOTO RELEASE

We use photos of participants in Pomeroy publications, including the website, to promote the Pomeroy Center. Indicate below if you approve or not. We will ask the parent's permission if an organization other than the Pomeroy Recreation and Rehabilitation Center wishes to publish pictures of our clients.

☐ You may use my child's photo for Pomeroy Publications ☐ Please do not use my child's photo

DOCTOR'S INFORMATION

Physician to be called in case of emergency:

Name: _____ Phone: (____) _____
Address: _____ City: _____ Zip: _____

If physician **cannot be reached**, what action should be taken?

Insurance Name & Number or Medical Number: _____

AUTHORIZATION FOR MEDICAL TREATMENT

☐ In case of an accident or an emergency, I authorize a staff member of PRRC to take my child to the above mentioned physician or to the nearest emergency hospital for such emergency treatment and measures as are deemed necessary for the safety and protection of my child at my expense.

☐ I hereby authorize the above named doctor or hospital to release any and all information in the medical records of:

Child's Name

_____/_____/_____
Birthdate

Parent's Signature

Today's Date