

**Presbyterian Church of Palm Harbor  
EMERGENCY FORM  
Children's Activities**

**A: STUDENT INFORMATION:**

Student Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Male OR Female

Grade \_\_\_\_\_ School \_\_\_\_\_

**B: PARENTS/GUARDIANS: EACH TO BE LISTED SEPARATELY:**

Name 1 \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Cell Phone \_\_\_\_\_ Employer Office Phone \_\_\_\_\_

Name 2 \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Cell Phone \_\_\_\_\_ Employer Office Phone \_\_\_\_\_

**C: IN THE EVENT PARENTS/GUARDIANS CANNOT BE REACHED, CHILD MAY BE RELEASED TO:**

*(Minimum of two contacts)*

Name Relationship Daytime #s \_\_\_\_\_

Name Relationship Daytime #s \_\_\_\_\_

Name Relationship Daytime #s \_\_\_\_\_

Should none of the above contacts be available, I hereby authorize the administration of any treatment deemed necessary by the following:

Preferred Physician/phone: \_\_\_\_\_

In the event of a life-threatening emergency or unavailability of preferred doctors, I authorize another licensed physician and/or the transfer of my child to the following hospital or any hospital reasonably accessible:

**D. Preferred Hospital:** \_\_\_\_\_

This authorization does not cover major surgery unless the medical opinion of two licensed physicians, concurring the necessity for such surgery, is obtained prior to the performance of the surgery. All doctors should be alerted to the information on this form concerning my child's medical history (allergies, medications, physical impairments, etc.)

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

**REFUSAL OF CONSENT:**

**I DO NOT GIVE CONSENT FOR EMERGENCY MEDICAL TREATMENT OF MY CHILD. IN THE EVENT OF ILLNESS OR INJURY REQUIRING TREATMENT, I WISH THE SCHOOL TO TAKE NO ACTION OR TO:**

\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL INFORMATION**

It is the sole responsibility of the Parent/Guardian to provide accurate medical information and updates in writing. PLEASE PROVIDE CLEAR AND LEGIBLE INFORMATION concerning the following, if applicable:  
Health, allergies, medication.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please attach or make a copy of the front and back of insurance card (s)