207 Skyline Boulevard • San Francisco, CA 94132
Main: (415) 665-4100 • Fax:(415) 665-7543
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

Name: ______________________________
Work Phone: (______) ____________________
Home Phone: (______)____________________
Cell Phone: (_______)____________________
Email: ______________________________

Father's / Guardian's Information

Name: ______________________________
Work Phone: (_____) ____________________
Home Phone: (_____)____________________
Cell Phone: (_______)____________________
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