

Pleasanton Community Services
Summer Zone @ Gingerbread Preschool 2013
Emergency Medical Release and Identification Form

FAMILY INFORMATION

Child's name (last name, first): _____ Birth date: _____
Mother's Name: _____ Lives with child YES NO
Mother's Address: _____ Home Phone (____) _____
Father's Name: _____ Lives with child YES NO
Father's Address: _____ Home Phone (____) _____
Mother's Company Name: _____ Work Phone (____) _____ Ext. _____
Company Address: _____ Cell Phone _____
Pager # _____
Father's Company Name: _____ Work Phone (____) _____ Ext. _____
Company Address: _____ Cell Phone _____
Pager # _____
E-mail Address: _____

PHYSICIAN TO BE CALLED IN EMERGENCY

Name _____ Telephone (____) _____
Address _____
Medi-Cal Number _____ Medical Insurance _____ Insurance Number _____

DENTIST TO BE CALLED IN EMERGENCY

Name _____ Telephone (____) _____
Address _____
Medi-Cal Number _____ Dental Insurance _____ Insurance Number _____

Food Allergies (life threatening)

If your child has a life threatening food allergy contact the Preschool Office IMMEDIATELY at 931-3430 to complete the Emergency Action Plan Form for Allergies

Food Restrictions (non life threatening)

Other Medical Limitations or Special Needs: _____

Consent to Medical Treatment of Minor

I hereby authorize any medical doctor, emergency medical technician, paramedic, nurse, healthcare provider, hospital, or other medical facility to treat my child for any illness, medical complication, allergic reaction, or injury received while my child participates in the Gingerbread Preschool Program. I authorize any licensed physician to perform any procedure, including the administration of anesthesia, that the physician deems advisable to treat any illness, medical complication, allergic reaction, or injury that my child may experience. I authorize any City of Pleasanton employee to perform any procedure, including the administration of epi-pens or medication (whether over the counter or prescription) that I have describe in the Emergency Action Plan Form for Life Threatening Allergies/Medical Condition to treat any illness, medical condition, allergic reaction, or injury that my child may experience. I realize that there is a possibility of complications and undesired and unforeseen consequences in any medical treatment and I assume any such risk on behalf of my child.

I represent that I am a parent or legal guardian of the child and I hereby agree to defend, hold harmless, and indemnify the City of Pleasanton, its Council, officers, employees, agents, and volunteers, and event holders, event sponsors, event directors, event volunteers, doctors, emergency medical technicians, paramedics, nurses, healthcare providers, and hospitals or other medical facilities from all liability, loss, costs, claims, or damages whatsoever that may be imposed upon said parties due to the medical treatment, or lack thereof, given to my child.

I have read this release, understand its legal implications, and agree to its terms.

Parent/Guardian Signature: _____ **Date** _____

Print Name: _____

If you have any questions regarding this form, please call the City Attorney's Office at (925) 931-5015.