

City of Albany
RECREATION & COMMUNITY SERVICES
FRIENDSHIP CLUB EMERGENCY CARD

CHILD'S NAME: _____ DOB: _____

ADDRESS: _____ HOME PHONE: _____

FATHER'S NAME: _____ WORK PHONE: _____

MOTHER'S NAME: _____ WORK PHONE: _____

EMERGENCY CONTACTS

NAME: _____ PHONE: _____ RELATIONSHIP: _____

NAME: _____ PHONE: _____ RELATIONSHIP: _____

MEDICAL INFORMATION

PHYSICIAN'S NAME: _____ PHONE: _____

CHILD'S MEDICAL #: _____

SPECIAL HEALTH CONSIDERATIONS: _____

I GIVE PERMISSION FOR MY CHILD, IN THE CASE OF A MEDICAL EMERGENCY, TO BE TRANSPORTED, AT MY EXPENSE, TO _____
IF I CAN NOT BE REACHED.

PEOPLE AUTHORIZED TO PICK-UP MY CHILD

NAME: _____ PHONE: _____ RELATIONSHIP: _____

NAME: _____ PHONE: _____ RELATIONSHIP: _____

NAME: _____ PHONE: _____ RELATIONSHIP: _____

PARENT/GUARDIAN SIGNATURE

DATE

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

**CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Children's Residential Facilities**

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME
PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____. THIS CARE MAY BE GIVEN UNDER WHATEVER
NAME
CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED
ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE
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WORK PHONE
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