

**EMERGENCY MEDICAL AUTHORIZATION  
SEVEN HILLS COMMUNITY RECREATION CENTER**

T-Shirt Size _____
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Student's Name \_\_\_\_\_  
Last First Initial

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

School Attended \_\_\_\_\_

**PURPOSE:** To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under Recreation Department authority, when parents or guardians cannot be reached.

**RESIDENTIAL PARENT or GUARDIAN**

Mother's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Other's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name of Relative or Childcare Provider \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**PART I or PART II (Must Be Completed)**

**~ PART I - TO GRANT CONSENT ~**

*I hereby give consent for the following medical care providers and local hospital to be called:*

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Medical Specialist \_\_\_\_\_

Local Hospital \_\_\_\_\_ Emergency Room Phone \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medication being taken, and any physical impairments to which a physician should be alerted:

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

**Date** \_\_\_\_\_ **Signature of Parent/Guardian** \_\_\_\_\_

**~ PART II REFUSAL TO CONSENT ~**

I do NOT give my consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the Recreation Department authorities to take the following action:

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

**Date** \_\_\_\_\_ **Signature of Parent/Guardian** \_\_\_\_\_

SEVEN HILLS COMMUNITY RECREATION CENTER  
HOME COMMUNICATIONS CARD  
Please Complete ALL Items

Participant's Name \_\_\_\_\_  
Last First Middle

Date of Birth \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Unlisted? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Your child will ONLY be released to the following people unless the Recreation Center Management is otherwise notified in advance.**

1. PARENT / GUARDIAN TO BE CONTACTED FIRST:

Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Secondary Phone \_\_\_\_\_ Cell Phone (if not already listed) \_\_\_\_\_

Address \_\_\_\_\_

RELATIONSHIP TO CHILD: \_\_\_\_\_ Parent \_\_\_\_\_ Step-Parent  
\_\_\_\_\_ Guardian \_\_\_\_\_ Grandparent \_\_\_\_\_ Other

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2. SECOND PERSON TO BE CONTACTED:

Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Secondary Phone \_\_\_\_\_ Cell Phone (if not already listed) \_\_\_\_\_

Address \_\_\_\_\_

RELATIONSHIP TO CHILD: \_\_\_\_\_ Parent \_\_\_\_\_ Step-Parent  
\_\_\_\_\_ Guardian \_\_\_\_\_ Grandparent \_\_\_\_\_ Other

.....  
3. THIRD PERSON TO BE CONTACTED:

Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Secondary Phone \_\_\_\_\_ Cell Phone (if not already listed) \_\_\_\_\_

Address \_\_\_\_\_

RELATIONSHIP TO CHILD: \_\_\_\_\_ Parent \_\_\_\_\_ Step-Parent  
\_\_\_\_\_ Guardian \_\_\_\_\_ Grandparent \_\_\_\_\_ Other