

# PROVIDENCE CREEK ACADEMY EMERGENCY CONTACT INFORMATION

## 2019 SUMMER CAMP

Camper's Name: \_\_\_\_\_ Male | Female (**circle one**)  
Last First  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Mother/Guardian's Name: \_\_\_\_\_ Father/ Guardian's Name: \_\_\_\_\_  
Mother's Place of Employment: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
Father's Place of Employment: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
Mother's cell: \_\_\_\_\_ Father's cell: \_\_\_\_\_

**If parents cannot be reached in case of an emergency, please list two individuals to contact:**

1<sup>st</sup> Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
2<sup>nd</sup> Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Camper's Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Camper's Dentist: \_\_\_\_\_ Telephone: \_\_\_\_\_  
My child has an EPI PEN | INHALER (**please circle**) PCA has the Epi pen or Inhaler: **YES | NO**  
Medical Problems: (**circle all that apply**) seizures hearing vision asthma other: \_\_\_\_\_  
List food, medication and environmental allergies: \_\_\_\_\_  
Medication student takes regularly: \_\_\_\_\_ How Often? \_\_\_\_\_  
Medical Insurance: \_\_\_\_\_ Policy/Group Number: \_\_\_\_\_

**In case of illness or injury, Providence Creek Academy will attempt to contact both parents at all numbers available to inform them of illness or injury, to determine transport. If the parent is unable to be reached, the emergency contacts will be called in the order they are listed. What is deemed as, appropriate medical care will be provided, including contacting the students physician and/or ambulance transfer to a medical facility for further care and evaluation.**

I, the parent/ guardian of \_\_\_\_\_, agree to the above emergency medical treatment procedure. I agree to assume responsibility for the cost of emergency care, including transportation by ambulance if necessary. I consent to any emergency care (treatment, surgery, diagnostic procedure, etc.) by a medical facility's physician that is necessary to ensure my child's health.

I \_\_\_\_\_ (Parent/guardian signature) give permission for a school administrator or the Camp Director to give my child non-prescription medication. (Tylenol, Ibuprophen, throat lozenges, topical ointments, etc.)

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