



MT. DIABLO AND YGNACIO VALLEY HIGH SCHOOLS
including the CARES After School Program
 (Collaboration for Academics, Recreation and Enrichment for Students)



PARTICIPANT EMERGENCY CARD
 (PLEASE PRINT)

STUDENT'S NAME LAST		FIRST		MIDDLE	NICKNAME
ADDRESS				City	ZIP
AGE	BIRTHDATE	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		HOME PHONE ()	
CHILD'S SCHOOL			GRADE	STUDENT ID#	
PROGRAM LOCATION: <input type="checkbox"/> MT. DIABLO HIGH SCHOOL <input type="checkbox"/> YGNACIO VALLEY HIGH SCHOOLS				HOW WILL YOUR CHILD RETURN HOME AFTER THE PROGRAM? <input type="checkbox"/> Will be picked up <input type="checkbox"/> Will walk at _____ p.m.	
				IS THIS STUDENT ELIGIBLE FOR FREE OR REDUCED PRICED MEALS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer	

MOTHER OR GUARDIAN'S NAME FIRST		LAST		FATHER OR GUARDIAN'S NAME FIRST		LAST	
HOME ADDRESS				HOME ADDRESS			
CITY		ZIP		CITY		ZIP	
EMPLOYER				EMPLOYER			
HOME PHONE ()		BUSINESS PHONE ()		HOME PHONE ()		BUSINESS PHONE ()	
PERSON RESPONSIBLE FOR CHILD							

CONTACT IN CASE OF EMERGENCY					
NAME	ADDRESS	CITY	ZIP	RELATIONSHIP	PHONE ()

OUT OF STATE - EMERGENCY CONTACT				
Please designate an out of state contact. This contact will be utilized only if all communications in the Bay Area are unavailable.				
NAME	RELATIONSHIP	STATE	HOME PHONE	BUSINESS PHONE

PERSONS OTHER THAN PARENT WHO MAY PICK CHILD UP			
FIRST NAME	LAST NAME	RELATIONSHIP	PHONE ()

SOURCE OF MEDICAL CARE/PHYSICIAN OR DENTIST TO BE CALLED IN EMERGENCY			
DOCTOR'S NAME			PHONE ()
ADDRESS	CITY	ZIP	KAISER OR MEDICAL PLAN NUMBER
DENTIST'S NAME			PHONE ()
ADDRESS	CITY	ZIP	DENTAL INSURANCE NAME/ PLAN NUMBER
IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN? <input type="checkbox"/> CALL EMERGENCY HOSPITAL <input type="checkbox"/> OTHER EXPLAIN:			

Please check box if your child has an allergy or health problem we should know about. Explain on reverse side of form.

(Over)

PRESENT MEDICAL CARE

Food Allergies? _____

Recent Illnesses? _____

Bee Sting Allergies? _____

List all medications presently taking: _____

List all reactions to any medications: _____

Authorization For Medical/Surgical Treatment

I hereby give permission to the medical personnel selected by program staff to order x-rays, routine tests, treatment, and necessary related transportation for me or my child. In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the Program Director to secure and administer treatment, including hospitalization, for my child as named above.

Transportation Release

The Mt. Diablo Unified School District/Bay Area Community Resources staff has my permission to release my child at 6 p.m. to walk, ride a bike or use public transportation. Once my child is so released I agree that the Mt. Diablo Unified School District/City of Concord/Bay Area Community Resources staff are no longer responsible for my child.

Photo Release

During your child's attendance, he/she may be participating in an activity that is being photographed. Occasionally, these photographs may be used for promotional purposes. My child may may not be photographed by the summer program for possible promotional purposes.

I understand that this is a public program operated by the Mt. Diablo Unified School District/City of Concord/Bay Area Community Resources. Under Civil Code 3344 I understand that my prior consent is not required for the use of my or my minor child's name, voice, signature, photograph or likeness in connection with any news, public affairs or sports broadcast or account, or any political campaign.

Program Evaluation Release

I understand that the Mt. Diablo Unified School District, the Mt. Diablo Unified School District/City of Concord/Bay Area Community Resources conduct evaluations to assess the quality of programs. I give permission for my child to be part of this program evaluation. I also understand that the information collected about my child will be kept confidential and that only persons connected with the Mt. Diablo Unified School District/City of Concord/Bay Area Community Resources and the evaluation will have access to this information.

Liability Release

I, the undersigned, certify that I am the legal parent or guardian of the above participant, that he/she is in good physical condition and I give my permission for him/her to participate in the activities at the programs except as noted. I further understand that the programs are physically active. Injuries and exposure to cold temperature are potential dangers. Proper clothing and equipment are required. I further acknowledge that potential injuries include strains, sprains, cuts, abrasions, broken limbs and even accidental death. I agree to assume full responsibility for any injuries or damages incurred or caused by him/her in connection with his/her attendance at the programs as regards the Mt. Diablo Unified School District/City of Concord/Bay Area Community Resources. This application is correct to the best of my knowledge.

Signature of Parent or Guardian _____ Date _____

Other pertinent information: _____

Additional children in the program:

1. Name _____ Grade entering in August 2011 _____

2. Name _____ Grade entering in August 2011 _____

3. Name _____ Grade entering in August 2011 _____

4. Name _____ Grade entering in August 2011 _____