CITY OF LOS ANGELES DEPARTMENT OF RECREATION AND PARKS

CLASS PARKS TEEN PROGRAM

EMERGENCY INFORMATION

Youth's Name:_____ Home Phone: (_____)_____
Address:_____
City:_____ State: _____ Zip Code:_____
Parent/Guardian:_____ Work Phone: (_____)_____
Parent/Guardian:_____ Work Phone: (_____)_____
Youth's Birthdate: _____ Age: _____ School:_____ Grade: _____
Medical Plan (insurance): _____ Allergies and/or medication:_____
Please list any medical conditions or restrictions: _____
_____
_____

If parents are not available, other authorized adults to call in an emergency:
Name: _____ Home Phone: (_____)_____ Work Phone: (_____)_____
Name: _____ Home Phone: (_____)_____ Work Phone: (_____)_____
Name: _____ Home Phone: (_____)_____ Work Phone: (_____)_____

PARENT/GUARDIAN PERMISSION

I hereby authorize my son/daughter _____ to travel (bus, van or walking) to any field trip/outing in association with CLASS Parks. I release the City of Los Angeles and its officials, agents, and employees from any liability in connection with this authorization.

DATE: _____ **PARENT OR GUARDIAN SIGNATURE:** _____

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR IN CASE OF EMERGENCY, ILLNESS, OR ACCIDENT

(I), (We), the undersigned parent(s)/guardian(s) of _____, a minor, do hereby authorize the **Directors and staff of the CLASS Parks program** as agent(s) for the undersigned to consent to any X-Ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or specific supervision of any physician or surgeon licensed under the provision of the Medical Practice Act, or the medical staff of a licensed hospital whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care that may be required, and it is given to provide authority and power on the part of aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his/her best judgment may deem advisable.

THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNTIL REVOKED IN WRITING AND DELIVERED TO SAID AGENT(S).

DATE: _____ **PARENT OR GUARDIAN SIGNATURE:** _____