GROVE CITY PARKS & RECREATION DEPARTMENT
614-277-3050 • 3226 Kingston Ave., Grove City, OH 43123
GroveCityOhio.gov • facebook.com/GroveCityOhio • twitter.com/GroveCityOhio • instagram.com/GroveCityOhio

P.A.R.K. PROGRAM EMERGENCY MEDICAL INFORMATION

Completed form must be submitted before entering the program.

PARTICIPANT INFORMATION

SCHOOL
❑ Bolton Crossing ❑ Buckeye Woods ❑ Highland Park ❑ J.C. Sommer
❑ Monterey ❑ Richard Avenue ❑ Hayes ❑ Holt Crossing ❑ Park Street

P.A.R.K. PROGRAM (CHECK ALL THAT APPLY)
❑ Morning K-4 ❑ After-school K-4
❑ Morning Intermediate

CHILD'S LAST NAME	**FIRST NAME**	**MI**

HOME ADDRESS	CITY	STATE	ZIP

BIRTH DATE (MM/DD/YYYY)	GENDER ❑ Male ❑ Female	GRADE ❑ K ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6	START DATE

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN LAST NAME	**FIRST NAME**	RELATIONSHIP TO CHILD

DAYTIME PHONE	CELL/OTHER PHONE	EMAIL

HOME ADDRESS	CITY	STATE	ZIP

EMPLOYER	WORK PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP

ADDITIONAL NUMBERS WHERE GUARDIAN CAN BE REACHED

PARENT/GUARDIAN LAST NAME	**FIRST NAME**	RELATIONSHIP TO CHILD

DAYTIME PHONE	CELL/OTHER PHONE	EMAIL

HOME ADDRESS	CITY	STATE	ZIP

EMPLOYER	WORK PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP

ADDITIONAL NUMBERS WHERE GUARDIAN CAN BE REACHED

EMERGENCY CONTACT INFORMATION

Emergency contact persons and persons who are authorized to pick up the child. These people must be local and able to reach the site within 30 minutes. If additional space is needed, please attach a separate sheet with the information.

CONTACT LAST NAME	**FIRST NAME**	RELATIONSHIP TO CHILD
DAYTIME PHONE	CELL/OTHER PHONE	ADDRESS
CONTACT LAST NAME	**FIRST NAME**	RELATIONSHIP TO CHILD
DAYTIME PHONE	CELL/OTHER PHONE	ADDRESS
CONTACT LAST NAME	**FIRST NAME**	RELATIONSHIP TO CHILD
DAYTIME PHONE	CELL/OTHER PHONE	ADDRESS
CONTACT LAST NAME	**FIRST NAME**	RELATIONSHIP TO CHILD
DAYTIME PHONE	CELL/OTHER PHONE	ADDRESS

MEDICAL PROVIDER/TRANSPORT:

PREFERRED MEDICAL PROVIDER INFORMATION			
MEDICAL CLINIC/OFFICE NAME	PHYSICIAN	PHONE	
FACILITY ADDRESS	CITY	STATE	ZIP
DENTAL CLINIC/OFFICE NAME	DENTIST	PHONE	
FACILITY ADDRESS	CITY	STATE	ZIP

COMPLETE PART I OR PART II. DO NOT COMPLETE BOTH.

❑ PART I: PERMISSION TO TRANSPORT CHILD

I give _____ my permission to transport
CHILDCARE FACILITY

my child, _____ ,
NAME OF CHILD

to _____ for emergency medical care
HOSPITAL/CLINIC

or to _____ for emergency dental care
DENTIST/CLINIC

or to the nearest available source of assistance.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

❑ PART II: REFUSAL TO GRANT PERMISSION TO TRANSPORT CHILD

I do **not** give _____ my permission to transport my
CHILDCARE FACILITY

child, _____ , for emergency medical or dental
NAME OF CHILD

care. In the event of an illness or injury which requires emergency medical or dental treatment, I want the childcare facility to take the following actions:

_____

_____

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

HEALTH RECORD:

1. List all allergies and any special precautions and treatment indicated for these allergies (e.g. medications required or foods or environmental modifications).
   - ❑ This does not apply to my child.

2. List medications, food supplements, modified diets or fluoride supplements currently being administered to the child.
   - ❑ This does not apply to my child.

3. List any chronic physical problems and any history of hospitalization.
   - ❑ This does not apply to my child.

4. List any diseases the child has had.
   - ❑ This does not apply to my child.

5. List any information that might be important for P.A.R.K. staff to know regarding your child.