EMERGENCY Contact Information and Release

Gathering Skills Programs

Participant

Full Name *Date of Birth*

Parent/Guardian

#1 Full Name *Phone* *Email*

#2 Full Name *Phone* *Email*

Emergency Contacts

Please provide 2 emergency contacts not listed above.

Full Name *Phone* *Email*

Full Name *Phone* *Email*

Physician Information

Physician's name: ____________________ Physician's Phone # ____________________

Insurance Company____________________ Policy # ____________________

Emergency Release

In case of emergency, take my child to the following hospital (please check one):

☐ Nearest Hospital OR ☐ (name of hospital) ____________________

If, in the judgment of James Horvath and/or Paula Horvath, the child named above needs immediate care and treatment as a result of any injury or sickness, I hereby give permission to the staff to secure proper treatment for my child. I do hereby consent to whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physician, surgeon or dentist and performed by or under the supervision of the medical staff of the hospital or facility furnishing medical or dental services.

It is further understood that the undersigned will assume full responsibility for any such action, including payment of costs. I do hereby agree to indemnify and hold harmless James Horvath and/or Paula Horvath from any claim by any person whomsoever on account of such care and treatment of said child.

Parent/Guardian #1

Full Name *Date*

Parent/Guardian #2

Full Name *Date*