



## EMERGENCY CONTACTS

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship: \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship: \_\_\_\_\_

## AUTHORIZED PICKUP

(OTHER THAN PARENT)

Name 1: \_\_\_\_\_ Phone \_\_\_\_\_

Name 2: \_\_\_\_\_ Phone \_\_\_\_\_

## MEDICAL INFORMATION

Preferred Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Medical Condition(s) \_\_\_\_\_

Allergies \_\_\_\_\_

Medication(s) \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

### Authorization for Emergency Medical Treatment

If my child, \_\_\_\_\_, should become ill or injured at, \_\_\_\_\_,  
Child's Full Name Name of Facility

I understand that the Facility will: (1) Contact the person (s) I have designated if I cannot be reached.

Should the facility be unable to reach me and/or the person (s) designated, they are authorized to contact my child's physician and/or arrange for immediate medical treatment.

The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

Sworn to and subscribed before me this \_\_\_\_\_, day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public, State of Florida- At Large.

My Commission Expires: \_\_\_\_\_

\_\_\_\_\_ who is/are personally known to me

\_\_\_\_\_ who has/have produced identification: \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Single Head of Household?  YES  NO      Number of persons in household \_\_\_\_\_

Family Income:    \_\_\_\$0-15,650    \_\_\_\$15,651-20,650    \_\_\_\$20,651-28,150    \_\_\_\$28,151- 34,440    \_\_\_\$34,441-45,100  
\_\_\_\$45,101 and up

List Adults in household \_\_\_\_\_

List other members of household you are financially responsible for: \_\_\_\_\_

List any additional income (*SSI, Child Support, etc...*) \_\_\_\_\_

Does your child qualify for special needs: \_\_\_\_\_ (*attach supporting documentation*)

Does your child receive free or reduced lunch at school \_\_\_\_\_ YES \_\_\_\_\_ NO (*attach supporting documentation*)

**NOTES**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Hillsborough County Ordinance** requires that parents must receive a copy of the "Know your child's Day Care Facility Brochure", and the parent's are notified in writing of the "Disciplinary Practices" used by the child care facility. The parent's or legal guardian's signature certifies receipt of the child care facility brochure/fdch brochure, discipline policies, agreement of the alternate nutrition plan, and that all the information on the form is complete and accurate.

Parents Email Address: \_\_\_\_\_

Child's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Child's Print: \_\_\_\_\_

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

Parent/Guardian Print: \_\_\_\_\_

**Police Athletic League**  
Parent Permission for PAL Sponsored Field Trips  
And Consent to Medical Treatment

Please complete both top and bottom of form

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(Name of Student) \_\_\_\_\_ has the opportunity to participate in an activity away from PAL premises.

NATURE OF ACTIVITY \_\_\_\_\_ See Current Program Calendar \_\_\_\_\_  
DESTINATION \_\_\_\_\_ See Current Program Calendar \_\_\_\_\_  
DATE \_\_\_\_\_ TIME OF DEPARTURE \_\_\_\_\_ DATE/TIME OF RETURN \_\_\_\_\_

TRIP SUPERVISOR \_\_\_\_\_ Group assigned coaches \_\_\_\_\_

MEANS OF TRANSPORTATION: (Sponsor please check)

- A. District-owned bus \_\_\_\_\_
- B. PAL owned bus \_\_\_\_\_
- C. PAL owned van \_\_\_\_\_

I understand the nature of the activities in which my son/daughter will be participating and that he/she is expected to abide by all PAL regulations during the course of the activity.

I understand that, PAL is liable or responsible for the conduct or safety of my son/daughter only while he/she is or should be under the immediate and direct supervision of an employee of the PAL.

I hereby give my permission for him/her to participate in the above-described activity.

I further agree that, in the event of an accident, illness or any other circumstance requiring medical treatment, such treatment may be procured for my son/daughter without financial obligation to PAL.

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

IMPORTANT MEDICAL INFORMATION THE COACH SHOULD KNOW: \_\_\_\_\_

EMERGENCY TELEPHONE NUMBERS: \_\_\_\_\_

THIS FORM SHOULD BE KEPT BY THE CHAPERONE DURING THE ACTIVITY  
(Please complete the form below)

**AUTHORIZATION TO TREAT A MINOR**

I (We), the undersigned parent, parents or legal guardian of \_\_\_\_\_, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of Florida Department of Public Health. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Date: \_\_\_\_\_ Signature of \_\_\_\_\_  
Father and/or Mother, or Guardian

Allergies to Drugs or Foods \_\_\_\_\_

Date of last Tetanus Booster \_\_\_\_\_ Contact Number \_\_\_\_\_

PLEASE COMPLETE BOTH TOP AND BOTTOM OF FORM

## Participant Questionnaire

Child's Name: \_\_\_\_\_

Welcome to the Police Athletic League of Tampa! Since emotional and maturity levels of children vary from child to child and also parent's opinion as to the proper handling of their specific children, we are asking that parents complete the following survey. This will assist us in molding our program to your child's specific needs.

How is your child's swimming ability?

Non-Swimmer     Poor     Fair     Good     Excellent

Has your child ever wandered away from a group or event?

Yes                       No

Does your child make friends or have confidence in adult strangers easily?

Yes                       No

If attending a movie, what is the highest rating allowed?

PG                       PG13                       R

What size T-shirt does your child wear \_\_\_\_\_ Child \_\_\_\_\_ Adult

Is PAL's staff allowed to apply sun screen or lotion as needed for outdoor activities?

YES     NO    If yes are there any special instructions? \_\_\_\_\_

List of child's previous After School \ Summer Programs \_\_\_\_\_

Please provide any information you care to that relates to your child, such as fears, basic personality, emotional needs etc. that might help us ensure they have a safe and enjoyable experience while at PAL.

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Parents/Guardians:

Please initial acceptance and receipt for the following handouts. Also, please list your child's name and sign at the bottom.

\_\_\_\_\_ I have received the Member Parent Guide

\_\_\_\_\_ I have received the "Know your Child Care Facility Brochure"

\_\_\_\_\_ I have received the Holiday Schedule

\_\_\_\_\_ I have completed all the appropriate paperwork

\_\_\_\_\_ I have provided copy of D.L. for each parent.

\_\_\_\_\_ I have provided copy of Pay stubs for each parent or proof of household annual income.

Child (rens) Names

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**Parent/Guardian Signature**

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**Date**