



RESTON COMMUNITY CENTER EMERGENCY CONTACT FORM



TRIP DESTINATION: _____ **DATE** _____

NAME _____

Your Name: _____

Address: _____

Street/Apt #

Town/City

State

Zip

Home Phone: _____ Pager/Cell: _____

FIRST EMERGENCY CONTACT

Name: _____ Relationship _____

Home Address: _____

Street/Apt #

Town/City

State

Zip

Home Phone: _____ Business Phone: _____

PHYSICIAN / MEDICAL CARE PROVIDER

Name of Physician: _____

Phone Number: _____ Health Insurance Provider _____

Provider's Phone Number: _____ Policy Number: _____

MEDICAL HISTORY

In case of Emergency, please list any medical conditions and/or medications you are currently taking that an attending physician should be aware of: _____

AUTHORIZATION: I give permission to the physician selected by the Reston Community Center to secure the administration of necessary medical treatment in case of an emergency. I also understand that any medical expenses incurred will be billed directly to my insurance company. In case of emergency, the Reston Community Center will use the closest available emergency facility.

Signature: _____ **Date:** _____

By my signature below, I hold the Reston Community Center, the Governing Board of the Center, the Fairfax County Board of Supervisors, the Employees of the Center and the volunteers, harmless from any and all liability for damages or harm arising from my participation in this program. I acknowledge that under Virginia law, the County, its agencies and, to a lesser extent, its employees, are immune from liability arising from legal suits based on tortious injury. Finally, I have been advised to carry my own insurance.

Signature: _____ **Date:** _____



RESTON COMMUNITY CENTER EMERGENCY AUTHORIZATION/ HEALTH HISTORY FORM



NAME _____

What procedure should we use in case of emergency? _____

(Notification? Insurance provider procedures? Religious request?) _____

Significant medical history/condition that an attending physician should know _____

Parent's/Guardian's Authorization: This health history is correct so far as I know and the person herein described has permission to engage in all prescribed trip activities, except as noted by me and the examining physician in the exceptions line below. In the event I cannot be immediately reached, I give permission to the physician selected by the Reston Community Center to secure proper treatment for, to hospitalize and to order injections, anesthesia and surgery for the participant, if needed.* I understand that any medical expense will be billed directly to me or to my insurance company. In the case of emergency, the Reston Community Center will use the closest available emergency medical facility.

*If parent or guardian has an objection to seeking emergency medical care, a statement to this effect must be annotated in the exceptions line below and the reason for the objection stated.

Exceptions: _____
By my signature below, I hold the Reston Community Center, the Governing Board of the Center, the Fairfax County Board of Supervisors, the Employees of the Center and the volunteers harmless from any and all liability for damages or harm arising from my participation in this program or if expelled from a trip. I acknowledge that under Virginia law, the County, its agencies, and to a lesser extent, its employees, are immune from liability arising from legal suits based on tortious injury. Finally, I have been advised to carry my own insurance.

Signature _____ Date: _____

My Insurance Provider is _____

My Physician is _____

Record Keeping Location/Physician _____

Medical Insurance Plan No. _____

RCC Program Administrator

Date