

MERAGE JEWISH COMMUNITY CENTER OF ORANGE COUNTY  
Children's Department 2010-2011  
**PICK UP AUTHORIZATION/EMERGENCY CONTACT**

Child's Name \_\_\_\_\_ Grade/School \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Email \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Email \_\_\_\_\_

Emergency Contact (non parent/guardian):

\_\_\_\_\_ Phone \_\_\_\_\_

The following have my permission to pick up my child:

\_\_\_\_\_ Number: \_\_\_\_\_

\_\_\_\_\_ Number: \_\_\_\_\_

\_\_\_\_\_ Number: \_\_\_\_\_

\_\_\_\_\_ Number: \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION FOR EMERGENCY MEDICAL  
AND/OR SURGICAL TREATMENT**

The authorization granted herein will be used ONLY WHEN ABSOLUTELY NECESSARY AND AFTER EVERY ATTEMPT HAS BEEN MADE TO CONTACT PARENT OR GUARDIAN.

AUTHORIZATION. In case of emergency, I hereby authorize the doctor or hospital to which my child may be brought (and whomever they may designate as their assistants) to perform any emergency procedure or operation, to give treatment and the administration of anesthetic to my child during his/her stay in camp.

LIST ALL ALLERGIES: \_\_\_\_\_

HEALTH INSURANCE: \_\_\_\_\_

INSURANCE ID #: \_\_\_\_\_

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

RELATIONSHIP TO CHILD: \_\_\_\_\_