

Participant's Name _____

Camp _____

GENEVA PARK DISTRICT

CAMPS 2010

SAFARI CAMP

VOYAGER CAMP

MIGHTY VIKINGS CAMP

ADVENTURE CAMP

TEEN X-TREME CAMP

SPECIALTY CAMPS

FORMS

***Please sign all forms and give to the Camp*

*Director on the first day.***

GENEVA PARK DISTRICT

EMERGENCY AND RELEASE FORM

PLEASE PRINT. Fill out all sections completely.

First Name:		Last Name:		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	School:	Grade:	
Address:		City:	Zip:	
Home Phone:		Email:		
Mother's First Name:		Last Name:		
Business Phone:		Cell Phone:		
Father's First Name:		Last Name:		
Business Phone:		Cell Phone:		
Do you have siblings in the program: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Sibling Name:		Age:		
Sibling Name:		Age:		

Please check one of the following: Summer Camp Winter Camp Spring Camp

Authorized persons, other than parents, who may be called in an emergency and/or pick up the child from the program. (All authorized must be 18 or older and will be required to show identification.)

1. Name _____ Relationship _____ Phone# _____
2. Name _____ Relationship _____ Phone # _____
3. Name _____ Relationship _____ Phone # _____
4. Name _____ Relationship _____ Phone # _____

Please list anyone one who DO NOT have authorization to pick up your child.

1. Name _____ Relationship to child: _____

Are there any custody/divorce or other family concerns that the staff should be alerted to? Yes _____ No _____

If yes, please explain: _____

Part I: ILLNESSES & INJURIES (Check any chronic or recurring illness)

- | | | |
|-----------------------------------|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Defect/Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Musculoskeletal Disorders |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Bleeding/Clotting | <input type="checkbox"/> Other: _____ |

Date of last Health Exam: _____ Date of last Tetanus Shot: _____

Family Physician _____ Phone # _____

Insurance Provider: _____ Policy # _____

Any activities to be restricted: _____

Part II: ALLERGIES (check any that apply and specify nature of allergic reactions)

- | | | |
|-----------------|------------------------|-----------------------|
| _____ Animals | _____ Insect Stings | _____ Pollen |
| _____ Food | _____ Medication/Drugs | _____ Other (specify) |
| _____ Hay Fever | _____ Plants | |

List specific allergies, reactions and special instructions: _____

Part III: MEDICATION (please list all, even if they are not taken at the site)

Is your child currently taking any medication? Yes No

List medication and the purpose of the medication:

Part IV: OTHER HEALTH CONDITIONS (check any that apply and describe below)

- | | | |
|------------------------------|-------------------------|-----------------------------|
| _____ Hearing Impairment | _____ Motion Sickness | _____ Nosebleeds |
| _____ Emotional Disturbances | _____ Fainting | _____ Wear Glasses/Contacts |
| _____ Special Diet Regimen | _____ Visual Impairment | _____ Speech Impediment |

Other important or helpful information: _____

The information above is correct to the best of my knowledge and I know of no reason(s), other than those listed above, why my child should not participate in the activities.

Signature of Parent/Guardian _____ Date _____

Part V: EMERGENCY CARE RELEASE

I, _____ parent [or legal guardian] of _____, have enrolled my child in _____, and hereby authorize Dr. _____, my child's physician, or any physician in his or her group practice, in my behalf to administer emergency medical assistance to my child during a Park District activity. In the event of a 911 emergency call or Dr. _____ or any physician in his or her group practice is not available, I hereby authorize the Geneva Park District, its employees and agents to provide emergency medical assistance or to arrange for and consent to on my behalf immediate medical treatment by a licensed or certified physician or other medical personnel for my child whenever the authorized Park District personnel believe such emergency medical assistance is necessary to protect the health, safety and welfare of my child.

Signature of Parent/Guardian _____ Date _____

LATE POLICY

It is important that you be on time when picking up your child. Children become worried when you are late. Teachers often have other obligations. Please note the time. Parents will be charged \$5.00 for the first 10 minutes of late time and \$1.00 for each minute after.

I understand the above policy, why there is a need for it and agree to abide by it.

_____ (Parent's Signature)

_____ (Date)



CONSENT/RELEASE FORM

*** Only for campers in Teen X-treme Camp, X-Treme Sports Camp, Wacky Water Camp for 11-14 year olds, or Nothing but Sports Camp for 11-14 year olds ***

_____ has my permission to walk to and/or from home to camp without being accompanied by an adult.

____ This applies to all camp dates of attendance.

____ This applies to only the following date(s) of attendance. (PLEASE LIST BELOW)

_____ (Parent's Signature)

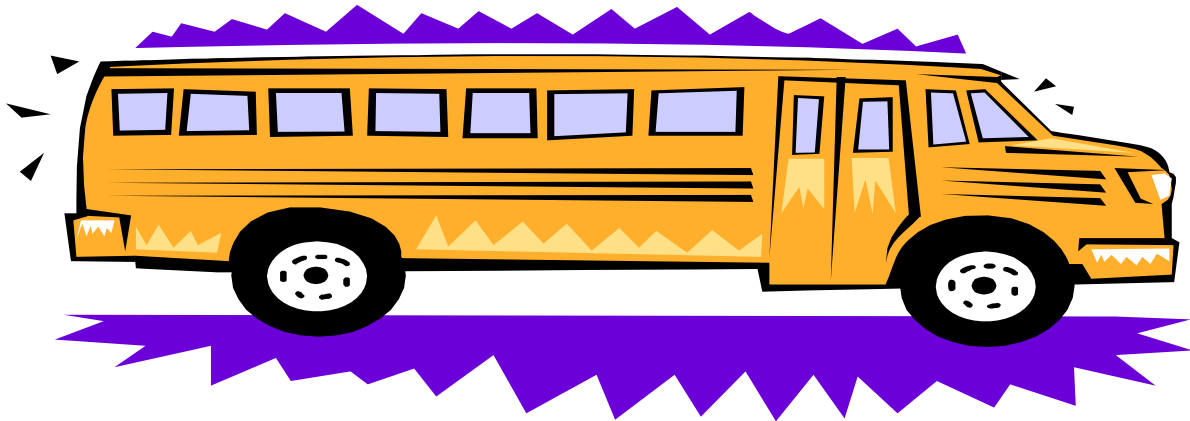
_____ (Date)

BEHAVIOR GUIDELINES ACKNOWLEDGMENT

I have read and understand the Behavior Guidelines that were established by the Geneva Park District to ensure a safe and enjoyable environment for all participants. I agree to the discipline procedures outlined in this manual.

(Parent's Signature)

(Date)



FIELD TRIP PERMISSION FORM

My child, _____, has my permission to go on any field trip (walking or by van/bus) sponsored by the Geneva Park District during the time my child is attending camp. Notification of any trips will be sent home prior to the date the trip is scheduled.

(Parent's Signature)

(Date)

**GENEVA PARK DISTRICT
REQUEST FOR THE ADMINISTRATION OF MEDICINE**

MEDICATIONS CANNOT BE ADMINISTERED AT THE PARK DISTRICT WITHOUT A DOCTOR'S WRITTEN ORDER AND A WRITEN REQUEST FROM THE PARENT OR GUARDIAN.

Name of Participant _____ Date of Birth _____
Address _____ City/Zip _____
Day Phone _____ Work Phone _____ Cell Phone # _____
Program _____ Grade _____

Part I - Physician's Statement

1. Name/type of medication _____
2. Dosage/amount to be given _____
3. Route of administration _____
4. Frequency and time of administration _____
5. Duration (week, month, indefinite, etc.) _____
6. Diagnosis, intended effect, and anticipated reaction to medication _____

(Symptoms, side effects, etc.) _____

7. Other medication child is receiving _____
8. Other requirements _____

9. Must this medication be administered during the Park District program in order to allow the participant to attend the program? Yes No

Physician's Signature

Date Signed

Address

Telephone No.

Part II - Parent's Request/Approval

I hereby request and grant permission for Park District staff to dispense medication to my daughter/son, _____, according to the above instructions. I further waive any claims against the Park District, members of the Board of Commissioners, its employees, and agents arising out of the administration of said medication and agree to hold harmless and indemnify the Park District, the members of the Board of Commissioners, its employees and agents, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorney fees, resulting from or arising out of the administration of medication.

Signed _____ Phone # _____ Date _____