Camper Authorization & Emergency Form

CAMP IMAGINATION

Please insert a current picture of the camper

To add a photo click the box to the right and browse your computer and click ok

Participant:	
Address:	
Grade Entering in Fall:	**School Attending:**

Birthdate:	**Age:**	☐ **Male** ☐ **Female**	

Mother/Legal Guardian:	
Home Phone:	**Cell Phone:**
Work Phone:	**Email Address:**
Father/Legal Guardian:	
Home Phone:	**Cell Phone:**
Work Phone:	**Email Address:**
Fears/phobias? □ **Yes** □ **No** **Please explain:**	**Medical conditions/limitations?** □ **Yes** □ **No** **Explain:**
Does your child have allergies? □ **Yes** □ **No** **Explain:**	**Does your child take any medications?** □ **Yes** □ **No** **Explain:**
Any dietary restrictions? □ **Yes** □ **No** **Explain:**	**Does your child require any special accommodations/assistance?** □ **Yes** □ **No** **Explain:**

Please add any additional information that you would like to share with us on a separate piece of paper to make your child's program with the Clarendon Hills Park District the most enjoyable. We appreciate your time and effort!

Participant's Name	
EMERGENCY NUMBERS AND TRANSPORTATION AUTHORIZATION	
Please list those authorized to transport your child from Clarendon Hills Park District Summer Camps. In the event that someone who does not usually transport your child should arrive for pick-up, they will be requested to produce a photo ID before a child will be released. **The individuals listed below will also be contacted in the event of an emergency or illness if we are unable to reach you. *Make sure contact is local and is able to pick-up in case of emergency.** *Please include individuals you carpool with on the list below. **YOU MUST NOTIFY CAMP DIRECTOR OR RECREATION SUPERVISOR OF CHANGES TO THIS FORM**	
1.Name (First & Last):	
Relation:	Phone:
2.Name (First & Last):	
Relation:	Phone:
3. Name (First & Last):	
Relation:	Phone:
Signature of Parent/Legal Guardian	***Date***

EMERGENCY CARE AUTHORIZATION	
In the event of any emergency, I hereby authorize Clarendon Hills Park District to secure from any licensed hospital, physician, or medical personnel any treatment deemed necessary for my child's/ward's immediate care and agree that I will be responsible for payment of any and all medical services rendered. I also authorize staff to administer CPR & First Aid for which they are trained. In case of an accident or health emergency, 911 will be called. Every effort will be made to contact parents or guardians immediately.	
Signature of Parent/Legal Guardian	***Date***

Authorization for my child to walk/bike home

My child has permission to leave the CHPD day camp site and walk/bike home without adult supervision. I understand that CHPD and its staff are not responsible for my child's safety at this time. Walkers/bikers are not to leave the camp site before the designated end of camp unless a signed note has been sent by parent/guardian.

☐ Yes **Signature**:______________________________

PARENT HANDBOOK ACKNOWLEDGEMENT

I have read and understand the rules, procedures and policies included in Parent Handbook.

Parent/Guardian Signature: ____**Date:** __________

Permission to Dispense Medication
Waiver and Release of All Claims

The Clarendon Hills Park District will not dispense prescription or over-the-counter medication to a minor child or other participant until the Permission and Waiver to Dispense Medication and Medication Information Form have been fully completed by a parent or guardian.

Reference:
Participant Name: ____

Program Participating In: ____________________________________

I,____, the parent/guardian of
(Print Parent/Guardian Name)

______________________________ give permission to the Clarendon Hills Park District staff to
(Print Participants Name)

administer the following: ____
(Print name of medication)

I understand it is my responsibility to give the medication directly to the program staff in individual dosage containers or original prescription containers clearly labeled with the following information.

Participants Name:____

Name of Medicine and Complete Dosage Instructions: ______________________________________

____

In all cases the recommended dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I give my permission to the Clarendon Hills Park District to secure from any licensed hospital physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any medical services rendered.

I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medication to my minor child. Such risks include, but are not limited to, failing to properly administer the medication, failing to observe side effects, failing to assess and/or recognize an adverse reaction, failing to assess and/or recognize a medical emergency and failing to recognize the need to summon emergency medical services.

In consideration of the Clarendon Hills Park District administering medication to my minor child, I do hereby fully release or discharge the Clarendon Hills Park District, and its officer, agents, volunteers and employees from any and all claims from injuries, damages and losses I or my child may have (or accrue to me or my minor child), and arising out of, connected with, incidental to or in any way associated with the administering of medication.

____ ____________________
Signature of Parent or Guardian Date

Medication Dispensing Information:

This form must be completed for each program session or when medication changes.

BACKGROUND INFORMATION:

Camper Information				
Last Name:	First Name:		Age:	
Address:		City:	State:	Zip:
Program Name:				

Parent/Guardian Information #1		**Parent/Guardian Information #2**	
☐ Ms.	☐ Mr.	☐ Ms.	☐ Mr.
First & Last Name:		First & Last Name:	
Home Phone:	Work Phone:	Home Phone:	Work Phone:

Doctor Information	
Last/First Name:	Work Phone:

MEDICATION INFORMATION:

1. Medication:______________________________Dose:_____________Time:_______

Dispensing & Storage Instructions:
____
____

Possible Side Effects:
____
____

2. Medication:______________________________Dose:_____________Time:_______

Dispensing & Storage Instructions:
____
____

Possible Side Effects:
____
____

3. Medication:______________________________Dose:_____________Time:_______

Dispensing & Storage Instructions:

____

____

Possible Side Effects:

____

____

OTHER INFORMATION:

____

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I understand it is my responsibility to give the medication directly to the program staff with full instructions in individual dosage containers or original prescription containers clearly labeled.

In all cases, medication dispensing can only be changed or modified by completing another Permission and Waiver to Dispense Medication Form and Medication Information Form.

I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, guardian ward, or other family member is accurate. I also understand that it is my responsibility to inform the agency if any changes in the dispensing of medication change.

____ __________________

Signature of Parent or Guardian **Date**