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:

_____

_____

_____

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**

ILLINOIS FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

Child's Photograph

NAME:_____ **D.O.B:**____/____/____

TEACHER:_____ **GRADE:**_____

ALLERGY TO:_____

Asthma: ◯ Yes (higher risk for a severe reaction) ◯ No

Weight: _____ lbs

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue)
SKIN: Many hives over body

Or Combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling
GUT: Vomiting, crampy pain

INJECT EPINEPHRINE IMMEDIATELY

- Call 911
- Begin monitoring (see below)
- Additional medications:
- Antihistamine
- Inhaler (bronchodilator) if asthma

Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis) → Use Epinephrine.

When in doubt, use epinephrine. Symptoms can rapidly become more severe.

MILD SYMPTOMS ONLY

Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: Mild nausea/discomfort

GIVE ANTIHISTAMINE

- Stay with child, alert health care professionals and parent.

IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE

☐ **If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.**
☐ **If checked, give epinephrine before symptoms if the allergen was definitely eaten.**

MEDICATIONS/DOSES

EPINEPHRINE (BRAND AND DOSE): _____

ANTIHISTAMINE (BRAND AND DOSE): _____

Other (e.g., inhaler-bronchodilator if asthma): _____

MONITORING: Stay with the child. Tell rescue squad epinephrine was given. A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.

☐ Student may self-carry epinephrine ☐ Student may self-administer epinephrine

CONTACTS: Call 911 Rescue squad: (_____)_____

Parent/Guardian: _____ Ph: (____)_____

Name/Relationship: _____ Ph: (____)_____

Name/Relationship: _____ Ph: (____)_____

Licensed Healthcare Provider Signature:_____ Phone:_____ Date:_____
(Required)

BY SIGNING BELOW: I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Community Consolidated School District 181 and its employees, agents, and employees who volunteer to do so on my behalf and stead, to administer or attempt to administer to my child (or allow my child to self-administer, while under the supervision of the School District employees, agents, and employees who volunteer to provide such supervision), lawfully prescribed medication in the manner described above. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees, agents and employees who volunteer as set forth above arising out of the administration or attempted administration of said medication. In addition, I agree to save, defend, hold harmless and indemnify the School District, its employees, agents, and employees who volunteer as set forth above either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts administration of said medication. I agree to save, defend, indemnify and hold harmless the School District and its employees, agents and employees who volunteer as set forth above against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by my child.

Parent/Guardian Signature:_____ Date:_____

Modified 4/20/17 by K.Katsenes