Emergency Form/Camper Information
Summer Day Camp 2020

Family Information

Parent or Legal Guardian's Name:	**Phone:**
Additional Parent or Legal Guardian's Name:	**Phone:**
Street Address:	
Apt. Building Number: **Apt. Unit Number:**	
City: **State:** **Zip Code:**	
E-mail Address:	

Participants First & Last Name	DOB	Grade for SY 20-21	Age	Gender	Camp Shirt Size
				Gender	
				Gender	
				Gender	

Pre/Post Camp: Are the children listed above in either Pre/Post Camp? ☐No ☐ Yes → ☐Pre ☐Post
Parent Manual: The parent manual will be given out at time of registration, please initial here that you received your parent manual and will read the manual. If you have any questions you can call or ask at the open house. _____
Child(ren) Physician: _____**Phone:** _____
In case of emergency, do you have a preference of what hospital your child is taken to? Please List.
_____

Do you allow camp staff to assist my campers in applying sunscreen? ☐Yes ☐No
*Campers are responsible to bring sunscreen from home. We cannot allow campers to borrow sunscreen. If you marked yes please know that staff will only assist in areas that your child can not reach themselves and please provide spray sunscreen.

Emergency Contacts/Authorized Pick-Ups

At least 1 adult (18 and older) emergency contacts are needed for each family other then the parent or legal guardians list above. All authorized pick up persons must be in high school or older. These are the ONLY names that will be able to pick up your child from the program, besides you. Please inform each person that they will need to bring a valid photo id when picking up your child.

Name	Relationship to Participant:
Cell Phone:	Work Phone:
Name	Relationship to Participant:
Cell Phone:	Work Phone:
Name	Relationship to Participant:
Cell Phone:	Work Phone:

Participant #1 Name: _____

Does your child take any medication (over the counter or prescribed)? ☐Yes ☐No
If yes, please specify: _____
Will your child have to take medication while attending the program? ☐Yes ☐No
If yes, please fill out the Medical Dispensing Form
Does your child have allergies to medications, food, environmental? ☐Yes ☐No
If yes, please list: _____
Are your Child's immunizations current? ☐Yes ☐No
If no, Please explain_____
When was your child's last Tetanus shot given? _____
Does this child have any chronic illnesses, or special education classifications (IEP) staff needs to be aware of? ☐Yes ☐No
If yes, please list: _____
Does your child have any special needs or require any accommodations? ☐Yes ☐No
If yes, please speak with Rebecca Perkaus to ensure that the needs of your child will be accommodated.
Are there any custody/divorce or other family concerns that our staff should be alerted to? ☐Yes ☐No
If yes, please list: _____

Participant #2 Name: _____

Does your child take any medication (over the counter or prescribed)? ☐Yes ☐No
If yes, please specify: _____
Will your child have to take medication while attending the program? ☐Yes ☐No
If yes, please fill out the Medical Dispensing Form
Does your child have allergies to medications, food, environmental? ☐Yes ☐No
If yes, please list: _____
Are your Child's immunizations current? ☐Yes ☐No
If no, Please explain_____
When was your child's last Tetanus shot given? _____
Does this child have any chronic illnesses, or special education classifications (IEP) staff needs to be aware of? ☐Yes ☐No
If yes, please list: _____
Does your child have any special needs or require any accommodations? ☐Yes ☐No
If yes, please speak with Rebecca Perkaus to ensure that the needs of your child will be accommodated.
Are there any custody/divorce or other family concerns that our staff should be alerted to? ☐Yes ☐No
If yes, please list: _____

Participant #3 Name: _____

Does your child take any medication (over the counter or prescribed)? ☐Yes ☐No
If yes, please specify: _____
Will your child have to take medication while attending the program? ☐Yes ☐No
If yes, please fill out the Medical Dispensing Form
Does your child have allergies to medications, food, environmental? ☐Yes ☐No
If yes, please list: _____
Are your Child's immunizations current? ☐Yes ☐No
If no, Please explain_____
When was your child's last Tetanus shot given? _____
Does this child have any chronic illnesses, or special education classifications (IEP) staff needs to be aware of? ☐Yes ☐No
If yes, please list: _____
Does your child have any special needs or require any accommodations? ☐Yes ☐No
If yes, please speak with Rebecca Perkaus to ensure that the needs of your child will be accommodated.
Are there any custody/divorce or other family concerns that our staff should be alerted to? ☐Yes ☐No
If yes, please list: _____

Summer Day Camp Programs
Medication Dispensing Form

Type of Medication: ☐ Daily ☐ Emergency (check one)

Name of Child:			
Purpose of Medication:			
Medication Name:		Expiry Date:	
Date Prescribed			
Time of last dose:			
Times to Administer Daily Medication:			
When to Administer Emergency Medication:			
Dosage:			

The label from the pharmacy must be attached to the medication.

Medication Location: ☐ To be kept on site ☐ Sent Home Daily (check one)

Medication Storage: ☐ Refrigerate ☐ Room Temperature (check one)

Are there side effects to the medication? ☐ Yes ☐ No (check one)

If yes, please describe or attach pharmacist's details:

_____

_____

_____

- If the child carries their own Medication (eg. Puffer) a note from a legally qualified medical practitioner or a nurse registered under the Health Disciplines Act should indicate that the child may carry and administer their own Puffer medication. A copy of the doctor's note will be kept on file.
- Each medication requires a separate medication form (eg. 2 Puffers require 2 forms)

I hereby authorize the Alsip Park District Camp Program and its employees and agents, on my behalf to allow my child to self-administer, lawfully prescribed medication in the manner described above during Camp, while under supervision of the employees of the Alsip Park District Camp Program. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF THE MEDICATION TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A NURSE OR HEALTH AIDE (i.e. Site Leader), AND SPECIFICALLY CONSENT TO SUCH A PRACTICE. I further acknowledge and agree that, when lawfully prescribed medication is so administered or attempted to be administered, I waive any claim I might have against the Alsip Park District, its employees and agents arising out of administration of said medication. In addition, I agree to hold harmless and indemnify the Alsip Park District, its employees and agents, either jointly or separately, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Parent Name: _____

Signature: _____ Date: _____