Summer Day Camp
Registration FORM

Drop off or mail to:
Allen County Parks
7324 Yohne Road
Fort Wayne IN 46809

Participant Information Section (Please Print Clearly): *Email: ____________________

Participant's Name: ______________________________ Nick-Name: ____________________
Birth Date: ______________ Age: ________ (during camp) Sex: ☐ Male ☐ Female
Address: ______________________________ City: ____________ State: ______ Zip: ________
Home Phone Number: __________________________ ***Program Session***: ____________________
Amount Paid: ________ ☐ $100/camper ☐ $90 Gold Park Pass Holder #

Legal Guardian & Emergency Information Section:

Legal Guardian's Name: ______________________________ Relationship: ____________________
Address If Different: ______________________ City: ____________ State: ______ Zip: ________
Day Phone Number: (   ) ______________ Evening Phone Number: (   ) ______________
Work Phone Number: (   ) ______________ Pager/Cell Phone Number: (   ) ______________

Additional Emergency Contact:
Contact Name: ______________________________ Relationship: ____________________
Phone Number: (   ) __________ Phone Number: (   ) __________ Phone Number: (   ) __________

Additional Emergency Contact:
Contact Name: ______________________________ Relationship: ____________________
Phone Number: (   ) __________ Phone Number: (   ) __________ Phone Number: (   )

Physician's Name: ______________________________ Office Phone Number: (   ) __________
Medical/Hospital Insurance: ______________________ Policy/Group Number: ____________________

Authorization for Pick-Up: **(MUST BE FILLED OUT)**
Persons authorized to pick up child **(other than legal guardian listed above)** :

1. Name: ______________________ Home Number: __________ Work Number: __________

2. Name: ______________________ Home Number: __________ Work Number: __________

Persons *NOT* authorized to pick up child.

1.______________________ 2. ______________________ 3. ______________________

Authorization to Administer Medication:
Although we encourage medication to be given to your child before or after the program, we understand there might be a need for your child to receive medication during program hours. A procedure has been established for medications to be administered by program staff. **Medications** must be brought to program location in the **original containers** with clearly written directions for usage. I hereby give my consent for the staff to administer medications to ______________________ as prescribed according to the below instructions. **(Legal Guardian Initials)** ________

MEDICATIONS: (**Please send all medications in original RX bottles with directions**)
Med. #1 ______________________ M T W Th F **Med. #2** ______________________ M T W Th F

Med. #3 ______________________ M T W Th F **Med. #4** ______________________ M T W Th F

Health History and Authorization for Treatment:

(All Questions Must be Marked)

In the past year....

1. Has this child required any counseling or hospitalization? **Yes or No** Explain ________________________________

____

2. Has this child had any operations or serious injuries? **Yes or No** Explain ________________________________

____

Does this Child...

3. Have an emotional, intellectual and/or physical disability? **Yes or No** Explain ________________________________

____

4. Have activity encouraged or limited by a physician? **Yes or No** Explain ________________________________

____

5. Have dietary modifications due to medical or religious guidelines? **Yes or No** Explain________________________

____

6. Use assistive devices? Glasses, Hearing, Leg Braces... **Yes or No** Explain ________________________________

____

7. Other? Legal Guardian concerns? Phobias, ***Allergies***...**Yes or No** Explain________________________________

Immunizations

My child's immunizations are up to date as required by Indiana Public Schools. **Yes or No**

If your child is not up to date as required by Indiana Public School please list the dates below or attach immunization record: (Month/Year, List last tetanus)

Vaccine	Month/Year	Vaccine	Month/Year	Vaccine	Month/Year
DTP	________	Haemophilus influenza B	________	MMR	________
Polio	________	Hepatitis B	________	Or Measles	________
Varicella (chicken pox)	________			Or Mumps	________
				Or Rubella	________

Authorization for Treatment:

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. I hereby give permission to the medical personnel selected by the parent to order X-rays, routine tests, treatment, and necessary transportation for the person herein described. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the **Allen County Parks Department** to secure and administer treatment, including hospitalization, for the person named above. The complete forms may be photocopied for trips off site. **(Parent Initials)** ___________

SIGNATURE OF LEGAL GUARDIAN IF PARTICIPANT IS UNDER 18 YEARS OF AGE

X____ **Date:**________________________

Requested Place for Treatment: (Hospital Name) ____

Waiver and Release From Liability Section: (Please Initial and Sign all lines below)

(I) (WE)________________________do hereby RELEASE and forever DISCHARGE the said **Allen County Parks Department** and their respective agents, officers and employees, from all claims, demands, damages or claims for relief on account of any and all injury which may exist or which may hereafter arise from participation in this Summer Day Camp Program. (I) (WE) do further agree to protect the said **Allen County Parks Department**, and their respective agents, officers and employees, from any damages incurred by way of claim, demand or judgement and agree to reimburse said **Allen County Parks Department** for any loss, damage or cost incurred. I affirm under penalties or perjury that (I) (WE) am 18 years of age or older, and that I executed the above foregoing WAIVER AND RELEASE FROM LIABILITY and that such are true and correct to the best of my knowledge and belief, this ____day of __________ , 20___.

(I) (WE) HAVE READ THIS DOCUMENT AND UNDERSTAND THAT IT IS A RELEASE OF ALL CLAIMS. (**Initials**)_____________

Photographic Release:

I hereby consent to and authorize **Allen County Parks Department** to reproduce photographs or video of my child for advertising and publicity purposes of any description. **(Initials)** ____________________

SIGNATURE OF LEGAL GUARDIAN IF PARTICIPANT IS UNDER 18 YEARS OF AGE

X **Date:**

____ ________________________