



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: _____ \$120/camper \$110 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: _____