



WAUKEGAN PARK DISTRICT
2017 Summer Day Camp Registration Form
Special Recreation TNT Summer Day Camps



13-22 years old with an intellectual disability

***Waukegan Park District Residents take precedence in registration. All Non-residents will be put on a waiting list for ALL CAMPS until June 5. After this date, no-residents can be added into any openings on a first come first serve basis. All registration paperwork and deposits must be completed at the time of registration.**

Camper Name: _____

TNT Camp AGES: 13-22 Developmental Disabilities 9:00 am – 5:00pm			
Belvidere Recreation Center			
*No Camp on Tuesday, July 4			
Session	Dates	Program #31102303 - Fee	Select
1A	6/19-6/30	\$192R /\$288 NR	<input type="checkbox"/>
2A	7/3-7/14	\$192R /\$288 NR	<input type="checkbox"/>
3A	7/17-7/28	\$192R /\$288 NR	<input type="checkbox"/>
1B	Select sessions of interest above.	Non-Resident Waitlist if registering before June 5	<input type="checkbox"/>

Please check the appropriate box regarding whether your child can swim:

_____ Yes, registrant is a swimmer, _____ No, registrant is not a swimmer but can go under water,

_____ No, registrant is just comfortable but has no swim skills, _____ No, registrant has a fear of water

This Registration Form & Deposit, along with the following items MUST be completed and turned in to the Waukegan Park District by the Registration deadline of June 4.

- ☐ Annual Information Form
- ☐ Participant Identification Form
- ☐ Medical Information Form
- ☐ Permission to Dispense Medication Waiver and Release of All Claims
- ☐ Seizure Form (For campers with a history of seizures.)

Camper Pick-up Authorization

Please list everyone authorized to pick-up your child from camp. This includes parents! Your child will only be released to those individual(s) on this list. Government ID is required at pick-up. If you need to add or remove a person from this list you may do so at any time in writing.

Name: _____ Relationship to Child: _____
Phone: _____

Name: _____ Relationship to Child: _____
Phone: _____

Name: _____ Relationship to Child: _____
Phone: _____

Name: _____ Relationship to Child: _____
Phone: _____

I authorize this child to participate in the Waukegan Park District Summer Day Camp Program and any on-site and off-site activities that are included. _____ (Initials)

I agree to pay any payment balances and fees by the deadlines set forth in the Waukegan Park District (WPD) Brochure. I understand that failure to make payments on time or violations of any procedures set forth in the WPD Brochure can result in forfeit of my deposits and any reserved spaces in the WPD Summer Camps. _____ (Initials)

Important Information

The Waukegan Park District (hereinafter referred to as WPD) is committed to conducting its recreation programs and activities in a safe manner and holds the safety of participants in the highest possible regard. The WPD continually strives to reduce such risks and insists that all participants follow safety rules and instructions that are designed to protect the participants' safety. However, participants and parent/guardians of minors registering for the below listed programs/activities must recognize that there is an inherent risk of injury when choosing to participate in recreational activities/programs.

You are solely responsible for determining if you or your minor child/ward are physically fit and/or skilled for the activities contemplated by this agreement. It is always advisable, especially if the participant is pregnant, disabled in any way or recently suffered an illness, injury or impairment, to consult a physician before undertaking any physical activity.

All persons registered for WPD programs thereby agree that any photographs or video taken by the WPD may be used by WPD for the promotional purposes including, but not limited to, posting the photograph/video on the WPD website, and/or its promotional videos, brochures, fliers, and other publications without additional, prior notice or permission and without compensation to the participant.

Warning of Risk

Recreational activities/programs are intended to challenge and engage the physical, mental and emotional resources of each participant. Despite careful and proper preparation, instruction, medical advice, conditioning and equipment, there is still a risk of serious injury when participating in any recreational activity/program. Understandably, not all hazards and dangers can be foreseen. Depending on the particular activity, participants must understand that certain risks, dangers and injuries due to inclement weather, slipping, falling, poor skill level or conditioning, carelessness, horseplay, unsportsmanlike conduct, premise defects, inadequate or defective equipment, inadequate supervision, instruction or officiating, and all other circumstances inherent to indoor and outdoor recreational activities/programs exist. In this regard, it must be recognized that it is impossible for the WPD to guarantee absolute safety.

Assumption of Risk, Waiver and Release of all Claims, Indemnification and Hold Harmless

Please read this form carefully and be aware that in signing up and participating in the identified programs/activities, you will be expressly assuming the risk and legal liability and waiving and releasing any and all claims for injuries, damages or loss which you or your minor child/ward might sustain as a result of participating in these programs/activities (including transportation services/vehicle operation, when provided).

I recognize and acknowledge that there are certain risks of physical injury to participants in these programs/activities, and I voluntarily agree to assume the full risk of any and all injuries, damages or loss, regardless of severity, that my minor child/ward or I may sustain as a result of said participation. I further agree to waive and relinquish all claims my minor child/ward or I may have (or accrue to me or my child/ward) as a result of participating in any and all programs/activities against the WPD, including its officials, agents, volunteers, independent contractors, instructors and employees.

I further agree to indemnify, hold harmless and defend the WPD and its officers, agents, servants and employees from any and all claims associated with the activities of this program.

In the event of an emergency, I authorize Park District Staff to secure from any licensed hospital, physician and/or medical personnel any treatment deemed necessary for my minor child/ward and agree that I will be responsible for the payment of any and all medical services rendered.

I have read and fully understand the above important information, warning of risk, assumption of risk, waiver and release of all claims, and indemnification and hold harmless. If registering on-line or via fax, my on-line or facsimile signature shall substitute for and have the same legal effect as an original form signature.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____



Annual Information Form 2017

Name: _____ Age: _____ Birth Date: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail: _____ Phone: _____ Sex: ☐ Male ☐ Female
T-Shirt Size: ☐ Youth ☐ Adult ☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ 2XL ☐ 3XL Shoe Size: _____
School/Workshop: _____ Teacher/Supervisor: _____ Phone: _____
Physician's Name: _____ Physician's Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Guardian Contact: _____ Relationship: _____
Primary Phone Number: _____ ☐ Home ☐ Cell ☐ Work
Secondary Phone Number: _____ ☐ Home ☐ Cell ☐ Work
Emergency Contact: _____ Relationship: _____
Primary Phone Number: _____ ☐ Home ☐ Cell ☐ Work
Secondary Phone Number: _____ ☐ Home ☐ Cell ☐ Work
Participant is Own Guardian? ☐ Yes ☐ No
Participant is independent and does not require supervision at conclusion of program/drop off. ☐ Yes ☐ No
If over 21 years, can individual consume alcohol? ☐ Yes ☐ No Quantity: _____

Photo / Video Authorization and Consent & Emergency Treatment Permission:

I hereby authorize and give my consent to SRSNLC to photograph/video my child (or me), and without limitation, to use such photographs/video in connection with promoting/advertising the services, programs, and facilities of SRSNLC, including, but not limited to its website, Facebook page, promotional materials, brochures, fliers and other publications without consideration of any kind. I have read and fully understand the above photo/video authorization and consent.

I acknowledge that SRSNLC does not carry medical insurance. My family's own health insurance must assume responsibility in the event of injury. I understand that every precaution is taken to protect the safety of every participant. I agree to emergency treatment by a physician or hospital in the event that I cannot be reached. I hereby acknowledge that the above information is accurate and I understand that it is my responsibility to inform the SRSNLC staff of any changes in the above information.

Medical Insurance Company: _____ Policy Number: _____
Signature of Parent/Guardian: _____ Date: _____

☐ I DO NOT authorize or give photo consent

INDIVIDUALS DISABILITY INFORMATION

Primary Disability: _____
Secondary Disability: _____

If Down Syndrome, has participant been tested for atlanto axial instability? ☐ Yes ☐ No ☐ N/A

Does your participant have atlanto axial instability? ☐ Yes ☐ No ☐ N/A

Not all personal care needs can be met by SRSNLC. Please contact your local office when requesting personal care needs.

HEALTH INFORMATION

Does participant have seizures? ☐ Yes ☐ No If Yes, please complete the SRSNLC Seizure Questionnaire. Even if there has been a past history of seizures.

Does the participant have asthma? ☐ Yes ☐ No Comments: _____

Allergies ☐ Food allergies Comments: _____
☐ Medication allergies Comments: _____
☐ Other allergies Comments: _____

Does participant carry/use an Epi-pen? ☐ Yes ☐ No

DIETARY INFORMATION

Does participant require assistance eating or drinking? ☐ Yes ☐ No Comments: _____

- have any food restrictions? ☐ Yes ☐ No Comments: _____
- have any food dislikes? ☐ Yes ☐ No Comments: _____
- have any specific food likes? ☐ Yes ☐ No Comments: _____
- is participant Diabetic? ☐ Yes ☐ No Comments: _____

If yes, participant must independently administer insulin.

SRSNLC-Waukegan Participant Identification Form

****Staff will add a photo on the first day of camp.****

Please fill out all information below:

Participant's Full Name	
Date of Birth	
Age	
Height & Weight	
Eye Color	
Hair Color	
Distinguishing Marks (Freckles, Birth Marks, Scars, Etc.)	
Names (nicknames) that they answer to:	

Participants Photo

WAUKEGAN PARK DISTRICT

PERMISSION TO DISPENSE MEDICATION WAIVER AND RELEASE OF ALL CLAIMS

(If more than three medications per participant, complete another form.)

Reference:

Participant name _____

Program participating in: _____

The Waukegan Park District (WPD) will not dispense medication to a minor child or other participant until the *Permission To Dispense Medication/Waiver and Release of All Claims* Form have been fully completed by a parent or guardian and *Annual/Participant Information Form* is updated as needed. The agency's internal procedures on dispensing medication are available for review.

This permission will be in effect from ____/____/____ to ____/____/____

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

_____, give permission to the
(Print Participant Name)

staff of the WPD to administer the following medication(s) to my child according to the Dose Instructions listed on page two.

I understand it is my responsibility to give only daily doses or amount for program activity, of the medication directly to the program staff in original prescription containers with the following information:

- Participant's name
- Name of medication
- Complete dosage instructions (amount and time of day)

If temporary containers must be used, see guidelines in procedures and allow a minimum of 3 business days prior to program to complete the approval process.

I understand that, if there is any discrepancy between the instructions I have written on this waiver and the prescription label, WPD staff will not dispense the medication until a parent/guardian or physician can be reached. If medication is needed for an emergency situation, I understand that the dispensing instructions used will be those from the original prescription container.

In all cases the recommended dosage of medication on original prescription container will not be exceeded, when administered by staff. If after administering medication, there is an adverse reaction, I give my permission to the WPD to secure medical treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered.

I recognize and acknowledge that there are certain risks of physical injury in connection with the administration of medication to my minor child. Such risks include but are not limited to, failing to properly administer medication, failing to observe side effects, failing to assess and/or recognize 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 WPD administering medication to my child, I do hereby fully release or discharge the WPD, and its officers, agents, volunteers, and employees from any and all claims from injuries, damages, or losses I or my minor child will 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

DOSE INSTRUCTIONS

Medication: _____

Dose _____ Time _____

Dispensing Instructions: _____

Storage Instructions: _____

Medication: _____

Dose _____ Time _____

Dispensing Instructions: _____

Storage Instructions: _____

Medication: _____

Dose _____ Time _____

Dispensing Instructions: _____

Storage Instructions: _____

**WAUKEGAN PARK DISTRICT
MEDICAL INFORMATION FORM**

Program: _____

General Information

Participant's Name: _____ Age: _____

Address: _____

Parent's/Guardian's Name: _____

Daytime Phone: _____ Other Phone: _____

Doctors Name: _____

Doctor's Phone Number: _____
(other numbers on the Emergency Contact form can be referenced)

In order for your child to have the best possible program experience, it is helpful for us to know if your child has ADD, ADHD, BD, learning disability, asthma, seizures, food allergies or anything else, which might affect his/her experience. Please disclose this type of information at your discretion.

Medication Information

Information on medications to be administered to the participant during program hours is required. In case of an emergency, it is also helpful to list any medication the participant receives on a regular basis but it is not mandatory that you share this information.

1. Name of Medication: _____ Dispensed by: ____staff ____guardian

Reason for medication: _____

Possible side effect: _____

2. Name of Medication: _____ Dispensed by: ____staff ____guardian

Reason for medication: _____

Possible side effect: _____

(Continued on Back)

3. Name of Medication: _____ Dispensed by: ____staff ____guardian

Reason for medication: _____

Possible side effect: _____

If a medication needs to be administered by Waukegan Park District staff, a 'Permission to Dispense Medication' form must be completed for each medication needing to be dispensed. In all cases, medication dispensing can only be administered, changed or modified by completing a 'Permission to Dispense Medication' form.

Other Information _____

Acknowledgement

I hereby acknowledge that the above information is accurate and I understand that it is my responsibility to inform the Waukegan Park District of any changes in the above information.

Signature of Parent or Guardian

Date



SRSNLC

SEIZURE QUESTIONNAIRE

Office use only:

Date Reviewed: _____

Initial: _____

Please complete this form if the participant experiences seizures. Please update this form whenever there is a change in the seizure information/plan and promptly submit it to SRSNLC. SRSNLC requests that you review this form once a year and provide any necessary updates.

Participant's Name: _____

Completed by: _____ Relationship: _____ Phone: () _____

Medication(s):

Participant medication needs are to be noted on their *Annual Information Form* which is available in this SRSNLC brochure. If the participant's medication needs have changed since submission of their *Annual Information Form*, please submit a new form as soon as possible.

A *Medication Permission* form must be submitted if you are requesting SRSNLC staff to assist with the dispensing of scheduled oral or topical maintenance medication. To obtain a copy of the *Annual Information Form* or *Medication Permission* form, please contact your local SRSNLC office or download a copy of the forms from your local SRSNLC website.

Please note: SRSNLC staff will not administer rectal Diastat or perform any other invasive medical procedures.

1. Please describe a typical seizure: _____

2. Are there any symptoms prior to the onset of the seizure? (i.e. smells, stomach pain, fear, sounds, etc.)

3. What was the date of the participant's last seizure? ____/____/____
4. How long does the typical seizure last? _____

Type of Seizure(s) (Please check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Absence (staring spell) | <input type="checkbox"/> Atonic (Drop) | <input type="checkbox"/> Simple Partial |
| <input type="checkbox"/> Complex Partial | <input type="checkbox"/> Generalized (Gran Mal) | |
| <input type="checkbox"/> Other (explain): _____ | | |

Seizure Response Plan

In the event of a perceived seizure, SRSNLC staff will follow basic first aid procedures for the care of seizures. Please list any additional actions you would like SRSNLC staff to take in the event of a seizure:

1. Call 911 for a seizure lasting more than _____ minutes. (Please Note: Depending on circumstances, SRSNLC staff may disregard this request and instead call 911 immediately)
2. _____
3. _____

Parent/Guardian Signature: _____ Date: _____

Please return this completed form along with your Registration Form to the SRSNLC office.

Rev. 1/31/17

