



Emergency Contact Information

Facility/School _____

Program/Activity _____

Program Dates _____

Participation

Full Week Partial Week Mon Tues Wed Thurs Fri Varies

Participant Information

Last Name, First Name _____ Male Female

Age _____ Grade Level _____ **Swim Level** Non-Swimmer Beginner Advanced Beginner

Parent/Guardian Information

Mothers/Guardian Name _____ Home Phone _____

Address _____ Work Phone _____

City, State, Zip _____ Cell Phone _____

e-mail _____

Fathers/Guardian Name _____ Home Phone _____

Address _____ Work Phone _____

City, State, Zip _____ Cell Phone _____

e-mail _____

Emergency Contact (other than parent/guardian)

Name _____ Relationship to participant _____

Address _____ Phone 1 _____

City, State, Zip _____ Phone 2 _____

Name _____ Relationship to participant _____

Address _____ Phone 1 _____

City, State, Zip _____ Phone 2 _____

Individuals authorized to pick up (other than parent/guardian)

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Physician & Insurance

Physician's Name _____ Physician's Phone _____

Hospital Preference, if any _____

Health Insurance Co. ID. _____ Group # _____

Dentist Name _____ Dentist Phone _____

Participant _____

Last Name

First Name

Medical & Physical Information

Please check if participant is subject to the following and explain:

Have you ever had...

- Allergies Yes No
- ADD/ADHD Yes No
- Autism/Aspergers Yes No
- Seizures Yes No
- Hepatitis A or B Yes No

- Diabetes Yes No
- Heart Problems/Murmur Yes No
- Asthma/Bronchitis Yes No
- Hernia Yes No
- Concussion Yes No

Do you wear...

- Glasses Yes No
- Contact Lenses
 - Hard Yes No
 - Soft Yes No

Details:

Is your child current on all school-required immunizations? Yes No Date of last tetanus inoculation: _____

Please list any medical history or physical restrictions that could affect participation in program/activities: Describe any past medical conditions, which might require special attention (if none please indicate).

Please identify any special adaptations or accommodations necessary to assist with participation in programs/activities:

Does participant take medicines at home? Yes No

Will participant need medicine administered by THPRD? Yes No If Yes, submit Medical Authorization Form.

Please read and sign below if you agree to the conditions herein:

I hereby give consent for my child to participate in all camp/recreational programs sponsored by Tualatin Hills Park & Recreation District (THPRD). I understand that activities run by the program may be vigorous at times, and although they are planned with the safety of the participants in mind, there is the risk of injury to my child arising from participation in this program.

I acknowledge that the THPRD is relying on my judgment, as well as my doctor's judgment, after examining my child to determine that my child has the physical and mental capacity reasonably necessary to engage in the program in which he or she has been enrolled. As my child's legal guardian, I agree to assume the risk associated with this program for him/her. By doing so, I hereby waive all claims against the Tualatin Hills Park & Recreation District or any of its officers, agents or employees, which may arise due to accident, sickness, injury or death, which my child might suffer from his/her participation in the Program. In the event of a medical emergency, I understand every effort will be made to contact me. If I cannot be reached, I give my permission for my child to be treated by a professional medical person and admitted to a hospital if necessary. I agree to be the party responsible for all medical expenses incurred. Signing this form will authorize THPRD to transport your child during the program. Any and all changes to this form must be done in writing and received by THPRD.

Signature of Parent/Guardian _____

Signature of Parent/Guardian _____





Medication Authorization

Facility _____
 Program/Activity _____
 Program Dates _____

TO BE COMPLETED FOR ALL PARTICIPATING PERSONS:

Participant Information

Last Name, First Name _____ Male Female

Age _____ Grade Level _____

List all medications including over-the-counter or non-prescription drugs that are to be administered during Camp.

NOTE: Prescription drugs must be in the original bottle, and non-prescription drugs must be in the manufacture's container with the label intact and age and dosage information legible. Children under 18 years of age should never be given aspirin unless a health care provider prescribes it, as aspirin is linked to Reye's Syndrome a serous and fatal disease. An adult must bring medication directly to Tualatin Hills Park and Recreation District (THPRD). Participants may not transport medication.

| Name of Medicine | Dosage | Specific Time to Administer | | | Reason for Taking |
|------------------|--------|-----------------------------|------|----|-------------------|
| | | AM | Noon | PM | |
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For campers requiring injections:

 INITIAL Generally, THPRD staff are not trained to administer emergency injections or other medical procedures. THPRD policy is to allow individual staff to voluntarily act under the statute ORS 30.800 through 30.807 and administer requested emergency injections or other medical procedures, should they individually choose to do so on a case-by-case basis. Instructions as to requested emergency injections or medical procedures must be provided by the physician. I request THPRD to inquire whether there are staff who are willing to consider acting under the statute ORS 30.800 through 30.807 on a case-by-case basis should my above named child need an emergency injection or other medical procedure in the manner described in the physician orders. THPRD cannot guarantee that it will find willing staff to act under the statute ORS 30.800 through 30.807 or that such staff will so act in every case.

 INITIAL Designated THPRD staff will dispense medication under physician's orders. Under statute ORS 30.800 through 30.807, all medications must be in a prescription container clearly labeled with the child's name, type of medication, dosage and times (both a.m. and p.m.) to administer medication to my above named child in the manner described by the physician's orders.

Parent/Guardian Signature _____ Date _____