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	Diabetes	☐ Yes	☐ No
ADD/ADHD	☐ Yes	☐ No	Heart Problems/Murmur	☐ Yes	☐ No
Autism/Aspergers	☐ Yes	☐ No	Asthma/Bronchitis	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Hernia	☐ Yes	☐ No
Hepatitis A or B	☐ Yes	☐ No	Concussion	☐ Yes	☐ No

Do you wear...

Glasses	☐ Yes	☐ No
Contact Lenses	☐ Yes	☐ No
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 this document carefully and completely before signing. Its effect is to release the Tualatin Hills Park & Recreation District ("THPRD") and its representatives from any liability resulting from participation in the Activities (defined below) and to waive all claims for damages or losses against THPRD and its representatives that may arise from such participation. Please 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 THPRD ("the Activities"). 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, and in exchange for my child's right to participate in the Activities, I hereby forever waive, release, and discharge THPRD and its individual directors, officers, agents, employees, volunteers, representatives, officials, and any other persons or entities acting on its behalf, and their successors and assigns (the "Released Parties") from any and all liability, claims, demands, actions, expenses (including attorney fees), damages, judgments, liabilities, and causes of action whatsoever, known or unknown (together, "Claims") arising from the fault or negligence of the Released Parties, including without limitation Claims for or related to any accident, sickness, disability, personal injury or death, which my child might suffer from his/her participation in the Activities unless caused by the Released Parties' gross negligence or willful misconduct. 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. I acknowledge that this Release will be governed by and construed in accordance with the laws of the state of Oregon without regard to conflict-of-law principles, and that if any of its provisions are found to be unenforceable, the remainder shall be enforced as fully as possible and the unenforceable provisions shall be deemed modified to the limited extent required to permit enforcement of the Release as a whole.

I have fully read and fully understand the release I am granting. 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 ______________________________

TUALATIN HILLS
PARK & RECREATION DISTRICT

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 serious and fatal disease. An adult must bring medication directly to Tualatin Hills Park & Recreation District (THPRD). Participants may not transport medication.

		Specifc Time to Administer			
Name of Medicine	**Dosage**	**AM**	**Noon**	**PM**	**Reason for Taking**

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 statue 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 ________________