Summer Camp 2018
Medical Release and Emergency Contact Information

Camp Attending: _____

Camper's Full Name (one participant per form): _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: M F

Grade Entering in the Fall (circle one): Pre-K K 1 2 3 4 5 6 7 8 9 10

Primary Email: _____ Secondary Email: _____

Parent/Guardian 1 Name: _____ Work/Cell Phone Number: _____

Parent/Guardian 2 Name: _____ Work/Cell Phone Number: _____

Do both parents have custody: Yes No If not, who is the custodial parent/guardian? _____

Persons to notify in case of emergency or illness if the parents cannot be reached:

Emergency Contact 1 Name: _____ Work/Cell Phone Number: _____

Emergency Contact 2 Name: _____ Work/Cell Phone Number: _____

Please provide information below that will help us to create a safe and healthy environment for your child. Lack of detailed information compromises our staff's ability to successfully accommodate your child. The Northfield Park District is not responsible for any injuries, complications, damages or losses due to lack of provided information. Many resources and adaptations are available to assist your child in having a successful summer.

Are your child's immunizations up-to-date? Yes No When was your child's last tetanus shot? _____

Allergies/Dietary Restrictions: _____

_____

_____

Medical Concerns/Medications: _____

_____

_____

If your child has medication that may need to be administered by NPD staff or medication that may be self- administered (including asthma inhalers), a Permission to Dispense Medication Form must be completed.

Is there anything else we should know about your child (fears, concerns, behavior issues, etc.) in order to provide a successful camp experience? _____

_____

_____

Please Complete Reverse Side.

Summer Camp 2018
Authorized Pick-up List

Camper's Full Name:_____ Date: _____

Parents/Guardians with custody and Emergency Contacts listed on the front have authorization to pick up the participant. Please list siblings, parents without custody, relatives, or friends who are also authorized to pick up your child. All individuals must present a photo ID upon NPD staff request in order for your child to be released into their custody. Only the custodial parent(s) may approve additions and/or changes to the Authorized Pick-upList.

Authorized Pick-up List:

Name:_____ Relation to Camper: _____

Cell Phone:_____ Addt'l Phone (home/work): _____

Name:_____ Relation to Camper: _____

Cell Phone:_____ Addt'l Phone (home/work): _____

Name:_____ Relation to Camper: _____

Cell Phone:_____ Addt'l Phone (home/work): _____

Name:_____ Relation to Camper: _____

Cell Phone:_____ Addt'l Phone (home/work): _____

If unable to contact a parent/guardian and if necessary, we will call emergency services (911) and your child will be transported to the nearest hospital at the parent/guardian's expense. Please see the parent handbook for additional medical procedure information.

Please list anyone who is NOT authorized to pick up your child:

Name:_____ Relation to Child: _____

Name: _____ Relation to Child: _____

Primary Physician:_____ Physician Phone: _____

Primary Hospital:_____ Hospital Phone: _____

I authorize the Northfield Park District to release my child to the above listed persons in the event that I am unable to pick up my child myself. I release the Northfield Park District from any and all responsibility once my child has been released into the custody of these above individuals.

Parent/Guardian Name:_____**Signature:** _____

Summer Camp 2018
Permission to Dispense Medication Form

Camper's Full Name (one participant per form): _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: M F

Parent/Guardian 1 Name: _____ Work/Cell Phone Number: _____

Parent/Guardian 2 Name: _____ Work/Cell Phone Number: _____

Doctor's Name: _____ Doctor's Phone Number: _____

Name of Medication	Dose	Time of Day	Purpose

Please indicate how the medication should be taken:

☐ Whole ☐ Chewed ☐ With Food ☐ Without Food ☐ With Water ☐ Without Water

☐ Other (please describe): _____

Please indicate how the medication should be stored:

☐ Refrigerated ☐ Room Temperature ☐ Other: _____

Please list any possible side effects of the medication: _____

_____

I understand it is my responsibility to give all medications directly to the NPD staff with full instructions in the original container, with only one day's dosage, with prescription labels including the following information:

Participant's Name
Name of Medication & Complete Dosage Information

I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medication to my minor child. Such risks include, but are not limited to, failing to properly administer the medication, failing to observe side effects, failing to assess and/or recognize an adverse reaction, failing to assess and/or recognize a medical emergency, and failing to recognize the need to summon emergency medical services.

In all cases, the recommended dosage of any medication will not be exceeded. If after administering a medication there is an adverse reaction, I give my permission to the Northfield Park District to secure from any licensed hospital physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered. In consideration of the Northfield Park District administering medication to my minor child, I do hereby fully release and discharge the Northfield Park District and its officers, agents, volunteers, and employees from any and all claims from injuries, damages, and losses I or my minor child may have or accrue, arising out of, connected with, incidental to, or in any way associated with the administering of medication.

I give permission to the Northfield Park District to administer the above stated medication to my child.

Print Name: _____ **Signature:** _____ **Date:** _____

Please review reverse side for the Medication Distribution Policy & Self-Administration of Asthma Information prior to signing.

Summer Camp 2018
Medication Distribution Policy

ACCEPTANCE & DISTRIBUTION OF MEDICATION

Medication distribution will be provided for participants who must take medication during a Northfield Park District sponsored program. Participants may not administer their own medication, with the exception of an asthma inhaler or epi- pen. All other prescribed or over the counter medications must be provided to NPD staff; participants may not retain possession of any medication while at a NPD program.

By completing the reverse side of this form, you acknowledge that the information provided is accurate. It is your responsibility to inform NPD if there are any changes in the dispensing of this medication. Modifications can only be made by completing a new Permission to Dispense Medication Form. A separate form must be completed for each medication.

Only a single dosage must be sent each day and it should be stored in the original container. If the original container is not available or it is an over the counter medication, a clearly marked container may be used. The container must list the participant's name, name of medication, and complete dosage information.

Every day that medication is provided to NPD staff, the date, time and initials of the staff member who accepted the medication will be noted in the Medication Log. Each time medication is dispensed to a participant, the date, time and initials of the staff member who administered the medication will be noted in the Medication Log.

NPD will not dispense medication to a minor child until the Permission to Dispense Medication has been fully completed by a parent or guardian. They agency's internal procedures on dispensing medication are available for review.

SELF-ADMINISTRATION OF ASTHMA MEDICATION

The Northfield Park District will permit the self-administration of medication by a participant with asthma, if the following documents are provided by the participant's parents or guardians:

1. Written authorization, signed by the parent or guardian; and
2. A written statement from the participant's physician, physician assistant or advanced practice registered nurse, containing the following information:
   A. The name and purpose of the medication
   B. The prescribed dosage; and
   C. The time or times at which or special circumstances under which the medication is to be administered.

SELF-ADMINISTRATION OF ASTHMA MEDICATION (Physician, Physician Assistant or Advanced Practice R.N.)

The following participant is under my care for asthma. Information relating to the participant's self-administration of the asthma medication referenced herein, which I have prescribed below:

Child's Name:_____ Date of Birth:_____/_____/_____

Name of Medication:_____ Dosage of Medication: _____

Purpose of Medication: _____

Time or special circumstance under which the medication is to be administered: _____

I have instructed in proper inhaler techniques & find that he/she is able to administer it independently.

Physician/Provider Signature:_____ Date:_____ Printed Name: _____

Address, City, State, Zip:_____ Office/Emergency Phone: _____

Parent signature giving permission for self-administration of medication for participant:

Parent Signature:_____ Date: _____