

JOHNSON COUNTY PARK AND RECREATION DISTRICT

ANTIOCH PARK CROSSROADS PERSONAL DATA SHEET

Please check weeks of attendance: 1 2 3 4 5 6 7 8 9 10

Participant's Name: _____ Age: _____ Birth Date: _____

Address: _____
Street City State Zip

Mother's Name: _____ Father's Name _____

Cell/Pager #: _____ Cell/Pager #: _____

Mother's Work #: _____ Father's Work #: _____

Home #: _____ Home #2 _____

Other emergency #: _____ (Relationship) _____

Doctor's Name: _____ Phone #: _____

Emergency Hospital Preference: _____

Any Food/Substance Allergies? _____

Is youth taking prescription drugs, specify? _____

Will drugs be administered during care hours, specify? _____

What activities does he/she enjoy most? _____

Is there any special information that would be helpful in meeting the needs of your youth?

Specifically state any physical limitations: _____

Please state goals for your child's participation in this program. _____

Have there been any major changes at home that may affect your child? _____

Please name all (including yourself) individuals who have permission to pick up your child from camp.

Signature of Parent/Guardian **X** _____ Date _____

