



JCPRD Youth Camp Form

2019

Personal Data

Before you begin: "SAVE AS" child's last name, first name & date of birth (01022018 no slashes) to your hard drive.

Please check **ALL** camps your child will be attending:

Specialty Camps

- Photography Camp 5/28
- Fishing & Canoeing 6/3
- Junior Naturalist 6/4
- Fishing & Canoeing 6/10
- Junior Naturalist 6/11
- June Bug Favorites 6/17
- Climbing & Rappelling 6/17
- Climbing & Rappelling 6/24
- Fine Art of Nature 6/24
- Off the Beaten Path 7/8
- Biking Camp 7/8
- Outdoor Adventures 7/15
- Wonderful Week of Water 7/15
- Outdoor Adventures 7/22
- Summer Daze 8/5 (Ages 6-8)
- Summer Daze 8/5 (Ages 9-12)

Outdoor Discovery Camps

- Ernie Miller Park (Ages 6-8):** 5/28 6/3 6/10 6/17 6/24 7/1 7/8 7/15 7/22 7/29
- Ernie Miller Park (Ages 9-12):** 5/28 6/3 6/10 6/17 6/24 7/1 7/8 7/15 7/22 7/29
- Shawnee Mission Park (Ages 8-12):** 5/28 6/3 6/10 6/17 6/24 7/1 7/8 7/15 7/22 7/29

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

Address: _____ City: _____ ST: _____ Zip: _____

Parent 1 Name: _____ Parent 2 Name: _____

Main Phone # _____ Main Phone # _____

Work # & Ext. _____ Work # & Ext. _____

List Food/Substance Allergies: _____

Allergy to bee or insect stings? Yes No Unknown

List any required medications & specify purpose: _____

Emergency contacts & individuals authorized to pick up your child (not including parents) (MUST HAVE PHOTO ID TO PICK UP CHILDREN)

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

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

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

Please state goals, if any, for your youth's participation in this program:

Signature of Parent/Guardian*: _____ Date: _____

* I attest that the information here provided is complete to the best of my knowledge. Typing my name in this box serves as my signature, for legal purposes pertaining to JCPRD programs, and KDHE requirements

This JCPRD Youth Program Form is applicable for many JCPRD Youth Programs & Camps. **Not all camps participate in the following activities.** Complete information will be necessary should the camper register in programs requiring such information.

HIGH RISK ACTIVITIES:

I give permission for my child to **PARTICIPATE** in the following High Risk activities: (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Swimming in Water beyond Chest Depth | <input type="checkbox"/> Archery (8yrs and older ONLY) | <input type="checkbox"/> Hiking |
| <input type="checkbox"/> Diving Board | <input type="checkbox"/> BB Gun Riflery (8yrs and older ONLY) | <input type="checkbox"/> Fishing |
| <input type="checkbox"/> Swimming (Pools & Beaches) | <input type="checkbox"/> Low Ropes Challenge Course | <input type="checkbox"/> Pond Exploration |
| <input type="checkbox"/> Canoeing & Kayaking* (8 yrs. and older ONLY) | <input type="checkbox"/> Pedal Boating* | <input type="checkbox"/> Stream Hikes |

* All campers are required to wear a lifejacket for boating activities

Please explain any limitations or concerns for your child participating in any camp activities:

List any fractures, dislocated joints, sprains, back or neck injuries, hospitalizations or surgeries your child has had in the last 3 years:

AUTHORIZATIONS

- **Transportation Authorization:** I authorize transportation in district or leased vehicles to Pools & Beaches, Stream Hikes, Boating/Fishing Sites, and any Johnson County Park & Recreation District Parks and Facilities. (In addition, guardians will need to sign weekly field trip permission forms.)
 AGREE*
- **Campers May Apply Health Products with Supervision:** (Check ALL that apply)
 Insect/Tick Repellent
 Sunscreen
- **Parent and Participant Code of Conduct Acknowledgement:** Please review the relevant program policy information for your program (available online) and review with your child. Program expectations and actions will be based on these policies and values.

I have read and understand the program mission, values, and policy statements and have reviewed the information with my child.

AGREE*

- **High Intensity Activities:** In addition to those listed above, my child may participate in supervised and appropriately challenging activities, as deemed by program staff.
 AGREE*

* I attest that the information here provided is complete to the best of my knowledge. Checking this box serves as my signature, for the legal purposes pertaining to JCPRD programs and KDHE requirements.



JOHNSON COUNTY
Park & Recreation
District



AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4- 582(e)(2).

Name of facility exactly as stated on the license.	License #
Outdoor Discovery Camp	EMP 453-010 / SMP 454-011

I hereby authorize Johnson County Park and Recreation District (Name of individual/staff member) and/or Outdoor Discovery Camp (Name of individual/staff member) who is (are) representative(s) of the above named facility to give consent for any and all necessary emergency medical care for my child or youth (First and Last Name of Child or Youth) while said child or youth is in said facility's custody between the dates of May 28, 2018 and until terminated.

* Signature of Parent or Guardian	Date Signed
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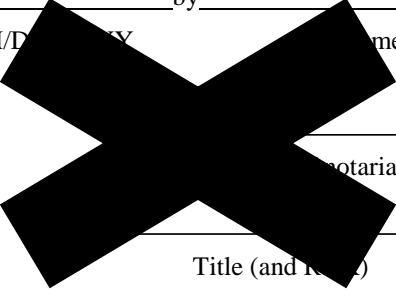
* I attest that the information here provided is complete to the best of my knowledge. Typing my name in this box serves as my signature, for legal purposes pertaining to JCPRD programs, and KDHE requirements

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	Date Signed
NOT REQUIRED NOT REQUIRED NOT REQUIRED	NOT REQUIRED

Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

State of Kansas
County of _____

Signed or attested before me on _____ by _____
MM/DD/YYYY Name of Person

(Seal, if any.) 

Notarial officer

Title (and Name)

My appointment expires: _____

List any known allergies or other information about the medical status of this child or youth pertinent in case of emergency:

Is child covered by health insurance? Yes No

If yes, complete the following:

Health Insurance Policy Name _____ Policy Number _____
Medical Assistance Program _____ Card Number _____
Military Medical Care I.D. Number _____

THE MEDICAL RECORD/ASSESSMENT FORM (OR HEALTH STATUS HISTORY FORM FOR SCHOOL AGE PROGRAMS) AND THE AUTHORIZATION FOR EMERGENCY MEDICAL CARE MUST BE TAKEN TO THE EMERGENCY ROOM. BOTH FORMS MUST ALSO BE IN A VEHICLE WHEN THE CHILD OR YOUTH IS TRANSPORTED BY THE FACILITY.



HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

Complete one form for each child or youth attending the School Age Program.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)
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First and Last Name of the Child's or Youth's Mother or Guardian

Mother/Guardian's Home Street Address	City	Zip Code	Home Phone #
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Mother/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone #
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First and Last Name of the Child's or Youth's Father or Guardian

Father/Guardian's Home Street Address	City	Zip Code	Home Phone #
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Father/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone #
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Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)
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Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.	City	Zip Code	Phone Number (during program hours):
1.			
2.			
3.			

First and Last Name of Physician & Street Address	City	Zip Code	Phone Number
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Name of Hospital Preference in case of emergency.
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Yes	No	N/A	Complete the following information about medications for this child or youth.
			Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
			If yes above, is there signed permission on file?

Check any of the following conditions or difficulties that affect this child or youth.			
Allergies <input type="checkbox"/>	Frequent sore throats/ colds <input type="checkbox"/>	Ear Infections or Aches <input type="checkbox"/>	Heart or Lung Conditions <input type="checkbox"/>
Skin Problems <input type="checkbox"/>	Asthma <input type="checkbox"/>	Headaches <input type="checkbox"/>	Diabetes <input type="checkbox"/>
Vision <input type="checkbox"/>	Speech/Communication <input type="checkbox"/>	Hearing <input type="checkbox"/>	Emotion/Behavior <input type="checkbox"/>
Other: Please describe.			

If you checked any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.)

Complete the following information about this child's or youth's immunization status.

Yes	No	
		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
		If yes, are this child's or youth's immunizations current?
X	X	If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)					
	POLIO					
	MMR					
Single Dose Only	RUBEOLA (MEASLES)					
	MUMPS					
	RUBELLA (GERMAN MEASLES)					
	HIB (Hemophilus Infl. B) *RECOMMENDED					
	HBV (Hepatitis B Vaccine) *RECOMMENDED					
	VAR (Varicella-Chicken Pox) *RECOMMENDED					

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed

If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form	Date Signed



Johnson County Park and Recreation Waiver Statement

WAIVER STATEMENT: The undersigned states that he/she understands that the Johnson County Park and Recreation District is not and shall not be responsible for or liable for any illness, or injury to person or damage to property resulting from the program in which the undersigned is enrolling or being enrolled or from his/her participating in said program, and the participant and the undersigned, if the participant is a minor or under other legal disability, hereby forever releases and holds harmless the said Johnson County Park and Recreation District, its employees, agents

and representatives from any and all claims of any kind that the participant, or the undersigned or their respective heirs, executors, administrators, or assigns may have or claim to have resulting from participation in said program.

NOTICE: By enrolling in this program you hereby acknowledge the Johnson County Park and Recreation District can and may photograph and/or video tape program participants and then use such images, without payment or any other consideration, for purposes of publicizing District parks, facilities, programs or services, or for any other lawful purpose.

I have read and I understand the Waiver Statement.

Signature of Parent or Guardian*

Participant Name*

Date

* I attest that the information here provided is complete to the best of my knowledge. My typed name acts as my signature, for the legal purposes pertaining to JCPRD programs and KDHE requirements.

Final Checklist:

- I have completed & signed the Personal Data Form & (pg. 1)
- I have completed the High Risk/ Authorizations (pg. 2)
- I have completed & signed the Authorization for Emergency Medical Care (pg. 3)
- I have completed & signed the Health History (pgs. 4-5)
- I have read, understand & signed the JCPRD Waiver (above)

Save and send! Remember to 'save as': last name first name and date of birth (01011984)

Email forms to: <mailto:PRK-ErnieMiller@jocogov.org>

- ➡ Camp forms must be completed and submitted prior to your child attending camp.**
- ➡ A parent/guardians signature is required. (A grandparent or nanny's signature is not acceptable)**
- ➡ If we do not have the correct signatures, or the forms are incomplete your child will not be able to attend camp.**

Privacy Disclosure: All contents of participant's release of liability, waiver, and health statement forms are confidential documents and will not be duplicated, distributed, discussed, and/or viewed by anyone other than the program facilitator, program staff, and emergency medical personnel unless otherwise required by law.