



Please print or type and complete one Personal Data Form for each child enrolled

JOHNSON COUNTY PARK AND RECREATION DISTRICT 2020 Summer Camp PERSONAL DATA FORM

JOHNSON COUNTY
Park & Recreation
District

School/Camp Name: _____

Child's Name: _____ Age: _____

Grade (2020-21) _____ Birth Date: _____

Address: _____
(Street) (City) (State/Zip)

Parent Name: _____ Home #: _____

Relationship to Child: _____ Work # & Ext. _____

E-Mail _____ Cell # _____

Parent Name: _____ Home # _____

Relationship to Child: _____ Work # & Ext. _____

E-Mail _____ Cell # _____

Emergency contact: _____ Phone #: _____

Relationship: _____

Phone _____

Relationship: _____

Doctor's Name: _____ Phone #: _____

Emergency Hospital Preference: _____

List Food/Substance Allergies: _____

Is child taking Prescription drugs, specify? _____

Will drugs be administered during care hours, specify? _____

The JCPRD program is authorized to release my child to the following individuals without advance written or verbal permission:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

(MUST HAVE PHOTO ID TO PICK UP CHILDREN)

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

Specifically state any physical limitations: _____

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

Will your child be leaving the camp for lessons, clubs, etc.? (Please state days/times)

List special programs, skills or activities you would like to have introduced in the program _____

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



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) |
|--|----------------------------|---------------------------------------|--|

| |
|---|
| 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 # () |
|--|-------------|-----------------|-----------------------------|

| | | | |
|---|-------------|-----------------|-----------------------------|
| Mother/Guardian's Work Place Name & Street Address | City | Zip Code | Work Phone # () |
|---|-------------|-----------------|-----------------------------|

| |
|---|
| 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 # () |
|--|-------------|-----------------|-----------------------------|

| | | | |
|---|-------------|-----------------|-----------------------------|
| Father/Guardian's Work Place Name & Street Address | City | Zip Code | Work Phone # () |
|---|-------------|-----------------|-----------------------------|

| |
|--|
| Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.) |
|--|

| | | | |
|---|-------------|-----------------|---|
| 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 () |
|--|-------------|-----------------|-----------------------------|

| |
|--|
| Name of Hospital Preference in case of emergency. |
|--|

| 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? |

| | | | |
|--|-------------------------------------|--------------------------------|---------------------------------|
| Circle any of the following conditions or difficulties that affect this child or youth. | | | |
| Allergies | Frequent sore throats/ colds | Ear Infections or Aches | Heart or Lung Conditions |
| Skin Problems | Asthma | Headaches | Diabetes |
| Vision | Speech/Communication | Hearing | Emotion/Behavior |
| Other: Please describe. | | | |

If you circled 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 |

Kansas Department of Health and Environment

Bureau of Family Health
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Program: (785) 296 -1270 Fax: (785) 296 -0803
Foster Care Program: (785) 296 -1270 Fax: (785) 296 -7025
Website: www.kdheks.gov/kidsnet



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 # |
|--|-----------|

I hereby authorize JCPRD Staff (Name of individual/staff member) and/or _____ (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 _____ and _____ until care is terminated .
MM/DD/YYYY MM/DD/YYYY

| | |
|---------------------------------|-------------|
| Signature of Parent or Guardian | Date Signed |
|---------------------------------|-------------|

| | |
|--|-------------|
| Witness to Parent's or Guardian's signature if required by the local hospital or clinic. | Date Signed |
|--|-------------|

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

| | |
|---|----------------------------|
| State of <u>Kansas</u> County of _____ | |
| Signed or attested before me on _____ MM/DD/YYYY | by _____ Name of Person |
| (Seal, if any.) | |
| _____ Signature of notarial officer | |
| _____ Title (and Rank) | |
| My appointment expires: _____ | |

Notary Not Required

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 _____

If known, date of last Tetanus inoculation: _____

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.