

## Personal Data

Primary Program to Attend: \_\_\_\_\_

T-Shirt Size: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

(Street)

(City)

(State/Zip)

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Main Phone # \_\_\_\_\_ Main Phone # \_\_\_\_\_

Work # & Ext. \_\_\_\_\_ Work # & Ext. \_\_\_\_\_

**Emergency contact:**

1. \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

2. \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Hospital Preference: \_\_\_\_\_

**List Food/Substance Allergies:**

Allergic to bees/insect stings? Yes No unknown

List any required medications & specify purpose \_\_\_\_\_

Will drugs be administered during program hours? Specify. (Please note a medication form must be on file to administer.)

**List all individuals authorized to pick up your child.**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

**(MUST HAVE PHOTO ID TO PICK UP CHILDREN)**

What activities does he/she most enjoy? \_\_\_\_\_

What special interests would your youth like to explore? \_\_\_\_\_

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

Specifically state any physical limitations: \_\_\_\_\_

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

Please state goals 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.

**Not all programs participate in the following activities.**

However, complete information will be necessary should the Youth register in programs requiring such information.

### **HIGH INTENSITY ACTIVITIES:**

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

- Swimming In Water Beyond Chest Depth      Archery(8yrs and older ONLY)      BB Gun Riflery(8yrs and older ONLY)
- Hiking    Stream Hikes    Pond Exploration      Diving Board      Fishing      Low Ropes Challenge Course
- Swimming(Pools & Beaches)      Canoeing & Kayaking\*(8yrs and older ONLY)      Pedal Boating\*      \* All campers are required to wear a lifejacket for boating activities

Please explain any limitations or concerns for your child participating in these 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\***

**Youth 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.



**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.**

<b>First and Last Name of the Child or Youth</b>	<b>Gender (M or F)</b>	<b>Date of Birth (MM/DD/YYYY)</b>	<b>First day at this program: (MM/DD/YYYY)</b>
--	----------------------------	---------------------------------------	--

<b>First and Last Name of the Child's or Youth's Mother or Guardian</b>
---

<b>Mother/Guardian's Home Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Home Phone #</b>
--	-------------	-----------------	---------------------

<b>Mother/Guardian's Work Place Name &amp; Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Work Phone #</b>
---	-------------	-----------------	---------------------

<b>First and Last Name of the Child's or Youth's Father or Guardian</b>
---

<b>Father/Guardian's Home Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Home Phone</b>
--	-------------	-----------------	-------------------

<b>Father/Guardian's Work Place Name &amp; Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Work Phone #</b>
---	-------------	-----------------	---------------------

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

<b>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.</b>	<b>City</b>	<b>Zip Code</b>	<b>Phone Number (during program hours):</b>
1.			
2.			
3.			

<b>First and Last Name of Physician &amp; Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Phone Number</b>
--	-------------	-----------------	---------------------

<b>Name of Hospital Preference in case of emergency.</b>
--

Yes	No	N/A	<b>Complete the following information about medications for this child or youth.</b>
			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?

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

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.

<b>Yes</b>	<b>No</b>	
		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
Single Dose Only	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Infl. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

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

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

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

<b>Signature of person completing this form*</b>	<b>Date Signed</b>
--	--------------------



**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 Johnson County Park & Recreation District (Name of individual/staff member) and/or Program Administration & Staff (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 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 o	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 _____ by _____			
MM/DD/YYYY	Name of Person		
(Seal, if any.)			
<b>NO NOTARY REQUIRED</b>			
		Signature of notarial officer	
		_____	
		Title (and Rank)	
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 \_\_\_\_\_

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.**

