Town of Clarkstown 2016 Camp/Playground Registration - Medical/Consent Form

A separate form MUST be completed for each child. Save to your PC & email: r.metz@clarkstown.org

CAMPER INFORMATION:

Last Name:		**First Name:**	
Address:		**Town/Hamlet:**	**Zip:**
Home Phone:		**Cell Phone:**	**Grade in Fall:**
E-mail:		**AGE:** **D.O.B:**	**GENDER:**

PROGRAM CODE		ACTIVITY NAME	FEE

Form of Payment
__Cash __Check #_____
__Visa __Master Card
TOTAL $

OFFICE USE

__Birth Certificate __Type of Residency

S.I. _____ Date _____

O.C. _____ Date _____

*****LAST DAY TO REGISTER FOR CAMP TRIPS IS THURSDAY June 30th, NO EXCEPTIONS!*****

EMERGENCY/PICK-UP INFORMATION:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

I hereby certify that I have read all rules and regulations governing programs and facilities I/we have registered for, and agree to abide by all such requirements and restrictions. I further certify that all above information is valid and correct. I give permission to Clarkstown Parks Board and Recreation Commission to use any pictures/video taken of my family for the Recreation & Parks Brochure or Town website. I verify that under penalty of perjury that my legal and permanent residence listed on this form is located within the Town of Clarkstown and the additional names listed on this form are also permanent residents.

X _____ X _____

Print Name of Participants/Parent/Legal Guardian — Signature of Participants/Parent/Legal Guardian — Date

MEDICAL INFORMATION:

Doctor's Name: _____ Phone#: _____

Please list any allergies (bee stings, foods, medications, etc.) _____

Please describe the symptoms of the allergy: _____

Are any medications or precautions necessary for the allergy (ie. Epi-Pen) _____

Is your child required to take medication or use an inhaler during camp hours? _____YES _____NO

If yes, please list: _____

Medical Comments – Limitations for camp activities (i.e. physical, visual, auditory, etc): _____

Medication can only be self-administered by the camper due to the fact that there is no RN on location.

Has your child recently been exposed to (in the last six months) to a communicable disease (such as measles, chicken pox or mumps, etc.)

☐ Yes Date: _____ ☐ No

IMMUNIZATION RECORDS: REQUIRED BY N.Y.S PLEASE FILL IN ALL DATES – NO ATTACHMENTS (Full Days Camps ONLY)

MMR Vaccine – Mumps, Measles, Rubella (3 doses):	1._____	2._____	3._____
OPV/IPV (Polio) (3 doses):	1._____	2._____	3._____
Varicella (Chicken Pox):	1._____		
Diphtheria/Tetanus DTP/DTaP (3 doses):	1._____	2._____	3._____
HiB (3 doses):	1._____	2._____	3._____
Hep B (3 doses):	1._____	2._____	3._____

EMERGENCY/TRIP AUTHORIZATION:

In the event that I cannot be reached and an emergency occurs, I hereby give permission to the physician selected by the Town to hospitalize and secure treatment for my child. I understand that the Town of Clarkstown does not offer accident insurance and that my personal insurance bears primary responsibility in case of an accident. I understand that by signing this form I give permission for my child to attend and travel to all Trips/Town Pools and Clarkstown inter-playground competitions that take place on days I send them to camp. I authorize the use of photos for promotional purposes.

X _____ _____

Parent/Guardian Signature (required) — Date

_____ _____

(For Office Use ONLY) Camp Medical Director — Date