

Enrollment Date: \_\_\_\_\_

## AFTER SCHOOL ENRICHMENT PROGRAM EMERGENCY CARD

Gender: (Please circle)  
M      F

AGE: \_\_\_\_\_

Child's Full Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

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

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

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

Mother's Address: \_\_\_\_\_

Father's Address: \_\_\_\_\_

Mother's Home Phone: \_\_\_\_\_

Father's Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Pager: \_\_\_\_\_

Pager: \_\_\_\_\_

Fax: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_

# INDIVIDUALS OTHER THAN PARENT/GUARDIAN AUTHORIZATION

Child's Full Name: \_\_\_\_\_

ONLY these individuals have my authorization to care for my child in the event of an emergency and/or for drop-off and pick-up.

Parent / Guardians Initial: \_\_\_\_\_

\* Please advise these individuals that they are authorized and will need to present identification to staff.

Name / Relation: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_

Name / Relation: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_

Name / Relation: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_

## WAIVER

I acknowledge by signing below that I am the parent or legal guardian of the above named child, being allowed to participate in any way in the Fort Lupton Recreation Center Programs, related events and activities including travel to and from. Sponsored or co sponsored by the: Fort Lupton Recreation Department, City of Fort Lupton, the undersigned acknowledges, appreciates, and agrees that: the risk of injury to my child from the activities involved in these programs, is significant, including the potential for permanent disability and death, and while particular rules, equipment, and personal discipline may reduce the risk, the risk of serious injury does exist. For my child, I knowingly and freely assume all such risks, both known and unknown, even if arising from the negligence of the releases or others, and assume full responsibility for my child's participation. I willingly agree to comply with the program's stated and customary terms and conditions for participation. For my child, and on behalf of my/ours heirs, assigns personal representatives and next of kin, hereby indemnify and hold harmless all the above releases from any and all liabilities incident to my involvement or participation in these programs, even if arising from their negligence, to the fullest extent permitted by law.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

# MEDICAL HISTORY AND INFORMATION FORM

Child's Full Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Please check illnesses that your child has had:

Chicken Pox \_\_\_\_\_ Measles \_\_\_\_\_ Rubella \_\_\_\_\_ Hay Fever \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_ Asthma \_\_\_\_\_ Epilepsy \_\_\_\_\_ Mumps \_\_\_\_\_

Poliomyelitis \_\_\_\_\_ Whooping Cough \_\_\_\_\_ Diabetes \_\_\_\_\_

Surgery/Accidents/Illnesses/Chronic Health Problems: \_\_\_\_\_

Describe any physical condition requiring special attention by center staff: \_\_\_\_\_

Check those allergies staff should be aware of and give the prescribed routine below.

Food (type) \_\_\_\_\_ Insect bites/stings \_\_\_\_\_

Penicillin \_\_\_\_\_ Other Drugs \_\_\_\_\_

Date of most recent examination of this child: \_\_\_\_\_

**Please record immunizations and dates administered on the Colorado Department of Health Certificate or Immunization on the other side of this form or attach a copy from your records.**

Physician/Health Care Professional: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Medical Insurance Co.: \_\_\_\_\_ Phone: \_\_\_\_\_

Group #: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital of Choice: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Any intolerance to drugs, medication, sunscreen or food? \_\_\_\_\_

This health record and information is correct as far as I know and the person herein described has permission to engage in all prescribed activities, unless otherwise stated.

Parent/Guardian initial \_\_\_\_\_

## CHILD'S SOCIAL HISTORY

A description of your child's behavior and reaction to various incidents is desired. This information is confidential and will be reviewed by the Recreation Manager and the School Age Director as a key to working with your child as an individual member of our program.

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Interaction with males: \_\_\_\_\_

Interaction with females: \_\_\_\_\_

Fears and dislikes: \_\_\_\_\_

Types of discipline used at home: \_\_\_\_\_

Reward system used at home: \_\_\_\_\_

Positive/negative school / camp experiences: \_\_\_\_\_

\_\_\_\_\_

Child's favorite activity: \_\_\_\_\_

Does your child currently have any emotional or behavioral problems and /or conditions such as Attention

Deficit Disorder?    YES    NO

If so, what steps have you taken to control this condition?

What works best at home for you and your child?

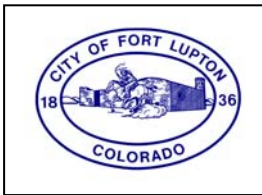
Does your child prefer to play alone?        YES    NO

Additional comments on child's social history: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PLEASE FEEL FREE TO DISCUSS ANY SOCIAL CONCERNS YOU MAY HAVE WITH THE RECREATION MANAGER AND / OR THE SCHOOL AGE DIRECTOR.



## AUTHORIZATION TO ADMINISTER MEDICATION

Note: For children who need to take over the counter or prescription medications during the after school enrichment program, this form needs to be completed in its entirety by a parent/ guardian and physician before any medication can be given by staff members. If the form is incomplete or not on file, the parent will be asked to return to the program to administer the medication regardless of the age of the child.

### Parents, please complete this section

The parent/guardian of \_\_\_\_\_ ask that the program staff give the  
(child's first and last name)  
following medication \_\_\_\_\_ at \_\_\_\_\_  
(Name of medication, one medication per sheet) (Time)  
to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

**Prescription medications** must come in the original container labeled with: child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped and licensed health care provider's name. Pharmacy name and phone number must also be included on the label. Ask your pharmacist for a separate medicine bottle to keep at the facility.

**Over the counter medication** must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packed in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the after school program staff.

\_\_\_\_\_  
Parent/Guardian's Printed Name                      Parent/Guardian's Signature                      Date

\_\_\_\_\_  
Home Phone                      Work Phone                      Cell Phone

### Health Care Provider Authorization to Administer Medication at the After School Program

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Route \_\_\_\_\_

To be given at the following time(s) (be specific, we cannot use "as needed") \_\_\_\_\_

Special Instructions \_\_\_\_\_

Purpose of medication \_\_\_\_\_

Side effects that need to be reported \_\_\_\_\_

Physician/Health Care Professional Signature: \_\_\_\_\_



## AUTHORIZATION TO PARTICIPATE/EXCLUDE PARTICIPATION IN ACTIVITIES

I give permission for my child to participate in all after school enrichment program activities with the following exceptions:

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Signature of Parent / Guardian

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Date

## AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I hereby give my permission to The Fort Lupton Recreation Center staff to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child \_\_\_\_\_ should an emergency arise. It is understood that the Fort Lupton Recreation Center after school enrichment program staff will make a conscientious effort to locate the parent/guardian or the emergency contact listed on the registration document before any action will be taken. If it is not possible to locate the emergency contact listed, I will accept the expense of emergency medical or surgical treatment.

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Signature of Parent / Guardian

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Date

## PARENT MANUAL RELEASE/STATEMENT OF UNDERSTANDING

I have read and understand the Fort Lupton Recreation Center's School Age Enrichment Program Parent Manual and understand the policies contained within.

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Signature of Parent / Guardian

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Date

## SUNSCREEN PERMISSION FORM

Children will apply sunscreen to themselves under the direct supervision of a school age enrichment program staff member 15-30 minutes before outdoor activities. Sunscreen will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by staff will be reported promptly to parent/guardian. It is the parent's responsibility to provide sunscreen with a specific amount of SPF they wish their child to have. Please have your child's first and last name clearly labeled on the bottle.

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Child's Name

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Name of Sunscreen and the SPF #

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Signature of Parent / Guardian

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Date

## BIKE/WALK FROM AFTER SCHOOL PROGRAM PERMISSION

My child \_\_\_\_\_ has my permission to bike or walk from the after school enrichment program and be released on his/her own. He/she will be responsible for signing him/her self out of the after school program each day. I agree that the Fort Lupton Recreation Center and employees will not be responsible for the welfare of my child once released to go home.

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Signature of Parent / Guardian

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Date