



2020 SUMMER DAY CAMP ENROLLMENT PACKET

Enrollment Date: _____

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: _____

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.

*We have forms for
Generalized meds,
Allergies and Asthma.*

*Please see me if
your child requires
medication on site.*

Thank You!
Julie Holm

**AUTHORIZATION TO
PARTICIPATE/EXCLUDE PARTICIPATION IN ACTIVITIES**

I give permission for my child to participate in all summer day camp activities with the following exceptions:

Signature of Parent / Guardian

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 summer day camp 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.

Signature of Parent / Guardian

Date

**PARENT MANUAL
RELEASE/STATEMENT OF UNDERSTANDING**

I have read and understand the Fort Lupton Recreation Center's Summer Day Camp Parent Manual and understand the policies contained within.

Signature of Parent / Guardian

Date

SUNSCREEN PERMISSION FORM

Children will apply sunscreen to themselves under the direct supervision of a summer day camp 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.

Child's Name

Name of Sunscreen and the SPF #

Signature of Parent / Guardian

Date

BIKE/WALK TO &/OR FROM SUMMER DAY CAMP PERMISSION

My child _____ has my permission to bike or walk to / from the summer day camp program and be released on his/her own. He/she will be responsible for signing him/her self in / out of the summer day camp 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.

Signature of Parent / Guardian

Date

City of Fort Lupton Recreation Center



203 South Harrison Avenue
Fort Lupton, Colorado 80621

Phone (303) 857-4200 Fax (303) 857-6421

www.fortlupton.org

FUN, FIT, FORT LUPTON

PARTICIPATION WAIVER AND RELEASE

I represent that I am the party registering for an activity with the Ft. Lupton Recreation Department or the parent or legal guardian of the child being registered herein and I am legally authorized to execute this Waiver and Release on behalf of my child and my family.

I hereby voluntarily allow my child to participate in activities and programs sponsored or run by the Ft. Lupton Recreation Department or that are otherwise sponsored by the City of Ft. Lupton and or the Ft. Lupton Recreation Center. I knowingly assume all risks of participation and waive any and all possible claims for personal injury or property damage against the City of Ft. Lupton, the Ft. Lupton Recreation Department, its employees, independent contractors, volunteers, management and staff that could possibly be incurred as a result of my participation or my child's participation in activities organized, run, or sponsored by the Ft. Lupton Recreation Department.

I hereby acknowledge that participation in physical activities and recreational programs of the Ft. Lupton Recreation Department may involve strenuous physical exercise that may include physical contact. I represent that neither I nor my child has any physical limitations that would prevent me or my child from participating fully in all activities organized, run, or sponsored by the Ft. Lupton Recreation Department.

As with any athletic or physical activity, I understand the inherent risks of injury associated with my participation and or my child's participation and I fully assume said risks. I am aware the risk of injury to my child or myself 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 this risk, the risk of serious injury does exist. I have knowingly executed and acknowledged this waiver of liability form with the full knowledge of the risks associated with participation in recreational activities at the Ft. Lupton Recreation Center or activities sponsored by the Ft. Lupton Recreation Department.

I represent that if I am injured or if my child is injured while participating in activities organized, run, or sponsored by the Ft. Lupton Recreation Department, I shall be financially responsible for any and all medical treatment that may be deemed necessary and I hereby release the City of Ft. Lupton, the Ft. Lupton Recreation Department, its employees, independent contractors, volunteers, management and staff from any liability associated with any injury that may be suffered by me or my child.

CHILD'S NAME: _____

PARENT'S PRINTED NAME: _____

PARENT'S SIGNATURE: _____

DATE SIGNED: _____

**Release of Claims, indemnity agreement and covenant not to sue.
This is a release of liability. Please read before signing.**

I, _____(name of climber), have made a voluntary request to use the Climbing Wall, ropes and other associated equipment (collectively "Climbing Wall") at the City of Fort Lupton Recreation Center and I do hereby agree to the following:

1. I understand that the Climbing Wall is a vertical wall constructed of texture coated plywood, ranging from beginning to advanced degrees of difficulty, including flakes, cracks, rappelling and hand holds. I acknowledge that my use of the Climbing Wall is inherently dangerous and will involve a significant risk of physical injury or death to me if I undertake to climb it and I am assuming this inherent risk by climbing it.
2. I freely, voluntarily and with such knowledge, assume the risk of risks associated with such activities including but not limited to death, personal injury property damage arising from or connected with my use of the Climbing Wall either with or without the supervision of city employees or other climbers. I take full responsibility for the ramifications of my actions and physical condition in connection with my use of the Climbing Wall.
3. I agree that I will not use the Climbing Wall except during the hours designated by the City and that I will use only the ropes provided by the City.
4. I have read and fully understand the official Climbing Wall rules provided by the City of Fort Lupton and agree to abide by these rules and regulations.
5. IN CONSIDERATION OF THE CITY PERMITTING ME TO USE THE CLIMBING WALL, I RELEASE THE CITY OF FORT LUPTON, ITS OFFICIALS AND EMPLOYEES AND THEIR SURETIES, AND EACH OF THE THEM FROM ALL LIABILITY, CLAIMS, CAUSES OF ACTION, OR COST AND EXPENSES WHATSOEVER ARISING OUT OF ANY DAMAGE, LOSS OR INJURY TO ME OR MY PROPERTY INCURRED FROM THE NEGLIGENCE OF THE CITY OF FORT LUPTON, ITS PUBLIC OFFICIALS AND EMPLOYEES AND THEIR SURETIES AND EACH OF THEM FROM SOME OTHER CAUSE.
6. I FURTHER AGREE FOR MYSELF, MY HEIRS, PERSONAL REPRESENTATIVES, EXECUTORS, ADMINISTRATORS AND ASSIGNS TO DEFEND, INDEMNIFY AND NOT TO SUE THE CITY OF FORT LUPTON, ITS PUBLIC OFFICIALS AND EMPLOYEES, THEIR SURETIES AND EACH OF THEM, AGAINST ANY AND ALL LIABILITY, CLAIMS, CAUSE OF ACTION, SUITS, DAMAGES OR EXPENSES OF EVERY KIND AND NATURE INCURED OR ARISING BY REASON OF ANY ACTUAL OR CLAIMED NEGLIGENT OR WRONGFUL ACT OR OMISSION BY ME OR BY THEM WHILE USING THE CLIMBING WALL.

I hereby represent that I have carefully read, understand and agree to the contents of the Release and sign the same voluntarily and of my own free will

CAUTION: READ THIS DOCUMENT IN FULL BEFORE SIGNING!

Name: _____

Address: _____ City: _____ Zip: _____

Telephone(home): _____ Work: _____

Date: _____ Signature: _____

(Adults 18 and over)

Name: _____ Signature: _____

(Parent/Guardian if under 18 years of age)

Contact in Emergency:

Name: _____ Phone: _____

General Health Appraisal Form

Parent: *Please complete*

Child's Name: _____ Birthdate: _____

Allergies: None Describe: _____

Type of Reaction: _____

Diet: Breast Fed Formula: _____ Age Appropriate

Special Diet: _____

Preventive creams/ointments/sunscreen may be applied as requested in writing by parent, unless skin is broken or bleeding.

Sleep: Your health care provider recommends all infants less than 1 year of age be placed on their back for sleep.

I, _____ give consent for my child's health provider, school or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (and applicable attachments) to my child's childcare provider, school, or camp. FAX Number: _____

Parent or Legal Guardian Signature _____ Date: _____
Authorization expires 365 days after this date

Health Care Provider: *Please complete after parent section has been completed*

Date of Last Exam: _____ Recent Weight: _____ **HCT: _____ ** B/P: _____ **Lead Level: _____

Physical Exam: Normal Abnormal (*see explanation of significant health concerns:*)

Significant Health Concerns: None Reactive Airways Disease Seizures Diabetes Developmental Delays

Vision Hearing Hospitalizations Severe Allergies Other (*dental, nutrition, behavior, etc.*) _____

Explain above concerns (if necessary, include instructions to childcare providers): _____

Current Medications/Special Diet: None Describe: _____

(Separate medication authorization form required for medications given in Child Care)

Fever reducer or pain reliever (*mark only one product: max. 3 consecutive days without additional medical authorization*)

Acetaminophen (Tylenol®) may be given for pain or fever over 102° every 4 hours as needed:

Dose _____ See attached Dosage Schedule from our office

OR

Ibuprofen (Motrin®, Advil®) may be given for pain or fever over 102° every 6 hours as needed:

Dose _____ See attached Dosage Schedule from our office

Immunizations: Up-to-date See attached immunization record Administered today: _____

Signature:

Next Well Visit: Per AAP Guidelines* or Age: _____

This child is healthy and may participate in all routine activities, sports, camps, and child care. Any concerns or exceptions are identified on this form.

Signature of Health Care Provider (certifying form was reviewed) _____ Date _____

Office Stamp: *Or write Name, Address, Phone Number*

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com



COLORADO

Department of Public Health & Environment

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: _____ Date of birth: _____

Parent/guardian: _____

Required vaccines

Immunization date(s) MM/DD/YY

Titer date*
MM/DD/YY

Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib <i>Haemophilus influenzae</i> type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella - date of disease _____ Varicella - positive screen date _____

*A positive laboratory titer report must be provided to the school to document immunity.

*The shaded area under "Titer date" indicates that a titer is not acceptable proof of immunity for this vaccine.

Recommended vaccines

Immunization date(s) MM/DD/YY

HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							

Health care provider signature or stamp: _____ Date: _____

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____ Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____