

Camp Rock

Summer Camp 2008



Registration Packet

Registration Checklist

Please ensure that all of the following forms are **carefully** completed. Failure to complete the registration packet fully may prevent your child from being able to participate in our program and its activities.

- General Information & Emergency Information Sheet
- Parental Permission, Consent and Agreement
- Authorization for Consent to Treatment
- Permission to sign in and out
- Swimming Information
- Health History

CITY OF LOS ANGELES - RECREATION AND PARKS
Eagle Rock Recreation Center
1100 Eagle Vista Drive, Los Angeles, CA 90041
Tel. (323) 257-6948

**GENERAL INFORMATION &
EMERGENCY INFORMATION SHEET**

Name: _____ Home Phone # (_____) _____

Address: _____

City: _____ State _____ Zip _____

E-mail address: _____

Father's Name _____ Work/Cell Phone # (_____) _____

Mother's Name _____ Work/Cell Phone # (_____) _____

Child's Birthday _____ Age _____ School _____ Grade _____

Medical Plan _____ Insurance# _____

Medical Problems: _____

If parents are not available, other adults authorized to take child from facility:

Name _____ Home Phone # (_____) _____ Work/Cell Phone # (_____)

Name _____ Home Phone # (_____) _____ Work/Cell Phone # (_____)

Name _____ Home Phone # (_____) _____ Work/Cell Phone # (_____)

E-mail Address _____

**If at any time information on this application changes,
Please notify the Director in writing immediately.
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PARENTAL PERMISSION CONSENT, AND AGREEMENT

I am aware that the City of Los Angeles, Department of Recreation and Parks carries **NO** insurance for my child.

I understand that there is no Child Care on trip days for children that are late or elect not to attend. This park has my approval and it covers all activities including those away from the park site which involve any type of transportation (bus, van, car, walking).

I understand that each child is expected to partake in all activities in which they are physically able.

I understand that each child is expected to wear appropriate clothing during camp hours and on field trips. Flip flops are not allowed on days that the children are on-site as they are expected to participate in the sports activity.

I understand that if my child does not wear his or her provided camp t-shirt, there will be no camp for them on that day. I am aware Camp Rock's "No shirt, No trip!" policy will apply to my child on all off site events.

I agree to pay on Wednesday of the week prior to each weekly session, or the 1st of each month for monthly sessions. I understand that if I wait to pay on the Monday of the session I may be assessed a \$10 late fee or be turned away due to lack of space in the program.

I understand that if my child is picked up late there will be a late fee charged.

I understand that any child or parent who does not cooperate with park staff will be expelled from the program, without a refund.

I further agree to relieve Eagle Rock Recreation Center and the City of Los Angeles, Department of Recreation and Parks, and its officers, agents and employees of any liability in connection with this agreement, and for any accident or injury that may occur during my child's participation in any recreation program at or away from this facility.

Dated _____ Signature of Parent or Guardian _____

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**AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR IN CASE OF
EMERGENCY, ILLNESS OR ACCIDENT**

(I), (We), the undersigned parent(s) of _____, a minor, do hereby authorize the staff of Eagle Rock Recreation Center as agent(s) for the undersigned to consent to an X-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provision of the Medical Practice Act or the medical staff of a licensed hospital whether such diagnosis or treatment is rendered at the office of said physician or at the said hospital .

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but it is given to provide authority and power on the part of aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgement may deem advisable.

This authorization shall remain effective continuously unless revoked in writing and delivered to said agent(s).

Date: _____ Father: _____

Mother: _____

Legal Guardian: _____

NOTE: The signing of this Consent to Treatment Authorization is not mandatory but is requested for your child's protection.

PERMISSION TO SIGN IN AND/OR OUT

I give my child _____ permission to:

(CHOOSE ONE) sign-in at _____ am; sign-out at _____ pm; sign-in and out at _____ am and _____ pm.

This means my child is able to leave the camp grounds and the care of staff without my presence. I am aware that loitering at the park is not allowed and that the staff is not responsible for my child before or after he/she signs out or before he/she signs in.

Signature parent/guardian _____ Date _____

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SWIMMING INFORMATION

Does your child swim? _____ Is your child a beginner intermediate advanced

Has your child had swimming lessons in the past? _____ If so where? _____

Does your child have a fear of water? _____

Are you comfortable letting your child swim in the ocean and or a lake? _____

HEALTH HISTORY FORM

THIS INFORMATION MUST BE FILLED OUT TO THE BEST OF YOUR KNOWLEDGE

Should anything happen to the child that would alter this health history information after this form is sent and before arrival at park, please let the park know immediately.

HOSPITAL: _____

INSURANCE: _____ POLICY NUMBER: _____

DOCTOR: _____

HAS THE CHILD HAD THE FOLLOWING: (PLEASE WRITE **YES** OR **NO**)

| | | | | | | |
|-----------------|--|---------------|--|--------------|--|---|
| Chicken Pox | | Mumps | | Colds | | Give the date of last immunization or booster |
| Measles | | Sinus Trouble | | Headaches | | Tetanus |
| German Measles | | Ear Infection | | Bedwetting | | Diphtheria |
| Rheumatic Fever | | Tonsillitis | | Fainting | | Whooping Cough |
| Scarlet Fever | | Appendicitis | | Constipation | | Polio |
| Asthma | | Upset Stomach | | Skin Rash | | Mumps |
| Heart Trouble | | Hay Fever | | Nosebleed | | Measles |

Does your child have any of the following:

Allergies:

Bee Stings, mosquitoes, etc.: _____ Medication: _____

Food (name): _____ Medication: _____

Asthma (hay fever): _____ Medication: _____

Serious injuries or illnesses: (if yes, please list) _____

Has the child received medical treatment in the past year? _____ Date: _____

Reason: _____

May the child be given aspirin or Tylenol if needed? _____ Pepto-Bismol? _____ Benadryl? _____

Does the child take medication at present? _____ If so, what kind, and what for? _____

Does the child have any special needs? _____