City of Los Angeles Department of Recreation and Parks
Echo Park Recreation Complex

AFTER SCHOOL CLUB 2018-2019

REGISTRATION FORM

(Please Print)

Child's Last Name: _____ First Name: _____

School Attending: _____Grade: _____ Room Number: _____ Teacher: _____

Child's Date of Birth: _____ Age: _____ I identify my Gender as: _____

Parent/Guardian: _____Legal Custody: ❒YES or ❒NO

Parent/Guardian: _____Legal Custody: ❒YES or ❒NO

Address: _____

City: _____State: _____Zip: _____

Home Phone: _____Work:_____ Cell:_____

Email Address: _____

In Case of Emergency, contact:

In case of an emergency, we will contact you first. In the event we are unable to reach you, please provide an alternate contact.

Name: _____ Relationship to Child: _____

Address: _____

City: _____State: _____Zip: _____

Home Phone: _____Work:_____ Cell:_____

AUTHORIZED SIGNATURE

We do not release children to friends, neighbors, or relatives, or divorced parents without written confirmation from the parent/legal guardian. **Please list both parents/legal guardians and all individuals authorized to pick up your child.** Individuals may required to show photo identification to pick-up your child.

In case I cannot be present, one of the following people have my permission to sign in or sign out my child at the scheduled time:

Name_____ Relationship_____ Phone#_____

Name_____ Relationship_____ Phone#_____

Name_____ Relationship_____ Phone#_____

Name_____ Relationship_____ Phone#_____

Signature of Parent/Guardian: _____ Date:_____

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WAIVER AND RELEASE FORM

In consideration of the City of Los Angeles acting through its Department of Recreation and Parks at **Echo Park Recreation Complex** granting the below-named child ("Minor") the opportunity to participate in the **After School Club** ("Program")

I, (print Parent Name) _____the undersigned, as the parent/guardian of (print Child's Name) _____("the Minor"), I do hereby agree as follows:

I am aware that there are certain risks of injury and/or damage inherent in the Program's activities;
I understand that if my child misbehaves and/or is sick and needs to be sent home; I agree to pick them up at the time requested by the staff;
I understand that the Program carries no insurance. I understand that the City at its sole option but without obligation may procure insurance to cover all or part of such medical expense incurred by Minor. Accordingly, I understand and agree that any cost incurred for such treatment which is not covered by insurance shall be my sole responsibility.
I agree to complete the Health History form providing Minor's current, complete and truthful health history; including immunization history and overall heath status;
I understand that under certain medical conditions the staff may require a written authorization based on a physical examination by a licensed medical person as requirement for the Minor to participate in the Program;
I confirm to the best of my knowledge and belief the Minor is neither subject to a physical or mental infirmity nor under the influence of any medication or substances which might hinder their safe participation or the safety of others in the Program;
I will instruct the Minor to abide by all safety rules, policies and regulations and to take reasonable precautions to minimize risks of injury or damage arising from participation in the Program;
I give my consent to have the Minor participate in all aspects of the Program;
I knowingly assume full responsibility for all risks of bodily injury, emotional injury, death or property damage that may occur in relation to the Minor as a consequence of participation in the Program;
I give my consent to have the Minor transported by: car, van, chartered bus, chartered school bus and/or public transportation as part of the Program;
I understand that the ASC has no obligation to obtain medical treatment for the Minor. Should it become necessary for the Minor the have emergency medical care while participating in the Program; **I hereby give the program personnel my permission** to use their judgment in obtaining medical care, and; **I give permission to the medical care provider** selected by the personnel to render medical care deemed necessary and appropriate;
Except for the gross negligence or willful misconduct of the ASC, I (print PARENT NAME)_____**waive** all rights of recovery which the Minor or I may have now or in the future, whether known or unknown, against the City of Los Angeles, Department of Recreation and Parks, **[ASC]** its officers, agents, employees and/or personnel, and
I release, acquit and forever discharge the City of Los Angeles, Department of Recreation and Parks, **[ASC]** its officers, agents, employees and/or personnel, from and all liability for any bodily injury, emotional injury, or other personal injury, damage, loss or expense, claims, demands, causes of action, costs, loss of services or use, compensations, debts, monetary damages, including but not limited to attorney fees, which result from or are in any way connected with the Minor's participation in the Program or any related activities;
I agree to keep the ASC advised if I will be out of contact for any period of time during the Program and to provide additional and/or alternate contact information prior to my leaving;
I also authorize the ASC, City of Los Angeles and Department of Recreation and Parks to make, procure and/or use photographs, films, tapes, digital media recordings or other likeness of the Minor's physical image and/or voice as for use with the Program and/or ASC's publicity, marketing and/or advertising materials;
I have read this agreement and I understand what it means to my legal rights and the Minors participation and by my signature made of my own free will and act;
I agree to abide by the rules and policies set forth in this registration, Parent Information Book and waiver release forms;
I have read and understand the payment, refund and conditions of enrollment policies as found in this registration form;
I agree to be legally bound by signing this registration and waiver release forms and extend this binding to the Minor(s).

Important: Parent or Guardians Original Signature Required.

Childs Name (please print) _____ **Date**_____

Parent/Guardian Name (please print)_____ **Date**_____

Signature_____ **Date**_____

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ASC HEALTH HISTORY FORM

Note: Should anything happen to the child that would alter his/her health history information after this form is returned, and before arrival at ASC, please let the staff know immediately.

Child's Last Name: _____ First Name: _____

❒MALE or ❒FEMALE Birth Date: _____ Age: _____

Address: _____

City: _____State: _____ Zip: _____

Parent / Legal Guardian (name): _____Phone #: _____

Doctor (name): _____Phone #: _____

Has the child had the following (please check):

☐ Chicken Pox	☐ Sinus Trouble	☐ Fainting
☐ Measles	☐ Tonsillitis	☐ Constipation
☐ German Measles	☐ Appendicitis	☐ Stomach Upset
☐ Rheumatic Fever	☐ Asthma	☐ Skin Rash
☐ Scarlet Fever	☐ Hay Fever	☐ Ear Infection
☐ Diphtheria	☐ Frequent Colds	☐ Nosebleeds
☐ Heart Trouble	☐ Headaches	☐ Other: _____
☐ Mumps	☐ Bed Wetting	

Give the month and year of last immunization or booster:

Tetanus	_____	Mumps	_____
Diphtheria (DPT)	_____	Measles	_____
Whooping Cough	_____	German measles	_____
Polio	_____	TB Test	_____ ❒POS or ❒NEG

Restrictions:

❒I have reviewed the program and activities and feel my child can participate without restrictions.
❒I have reviewed the program and activities and feel my child can participate with the following restrictions or adaptations: _____

_____

Allergies / Other (please specify):

❒Bee stings, mosquitoes, etc.:_____
❒Food (name): _____
❒Medication(s):_____
❒Asthma (or hay fever): _____
❒Other: _____

Has the camper received medical treatment during the past year? ❒YES or ❒NO
Date: _____Reason: _____

_____

Is the child taking any medications now? ❒YES or ❒NO

Parent/Guardian Signature: _____ Date: _____

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REQUEST FOR CHILD TO TAKE MEDICATION DURING ASC HOURS

I request that my child, ____, be allowed to take the following prescribed medicine(s) while at the ASC. I understand that staff of **the Program DOES NOT ADMINISTER MEDICATION** and will only provide the medicine to my child so that he/she may administer it to his/her self at the time, dosage and frequency indicated on the pharmacy label of the medicine bottle. My child must be able to administer the medicine to his/her self. "Medication" is any substance a person takes to maintain and/or improve health. This includes vitamins & natural remedies. All medications **must be in original pharmacy containers with labels**, no modifications. Please provide enough of each medication to last the entire time the child will be participate in program.

Name of Medicine: ______________________________# of Pills_________ Date Started _____________

When is it given: ❒Breakfast ❒Lunch ❒Dinner ❒Bedtime ❒Other ______________________

Amount of Dose Given:___________________________________ How is it given:____________________

Reasons for taking Medicine: ____

____

Name of Medicine: ______________________________# of Pills_________ Date Started _____________

When is it given: ❒Breakfast ❒Lunch ❒Dinner ❒Bedtime ❒Other ______________________

Amount of Dose Given:___________________________________ How is it given:____________________

Reasons for taking Medicine: ____

____

Name of Medicine: ______________________________# of Pills_________ Date Started _____________

When is it given: ❒Breakfast ❒Lunch ❒Dinner ❒Bedtime ❒Other ______________________

Amount of Dose Given:___________________________________ How is it given:____________________

Reasons for taking Medicine: ____

____

Parent/Guardian Signature: ________________________________ Date: ________________________

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AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR AT AUTHORIZED HOSPITAL IN CASE OF EMERGENCY ILLNESS OR ACCIDENT

I (We), the undersigned parent(s) of _____________________________, a minor do hereby authorize the directors/staff of **ASC** as agent(s) for the undersigned to consent to any 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 on the medical staff of a licensed hospital whether such diagnosis or treat is rendered at the office of said physician or at 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 best judgment may deem advisable. This authorization shall remain effective through the conclusion of the event, unless sooner revoked in writing and delivered to said agent(s).

Parent/Guardian Signature: ________________________________ Date: ________________________

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PARENT PAYMENT AGREEMENT

I (We) (Print Parent Name) _____ agree to pay the fees/charges due monthly by the designated due date of: **The 1st of Each Month.** Any payments done after the 5th of the month will be charged a $10.00 late fee. I understand that failure to make full payment after the 5th will result in my child being dropped from the After School Club (program). Furthermore, I understand that in such event, the Program Staff may notify the appropriate school personnel that my child has been discharged from the Program and that the staff is no longer responsible for providing After School care. To reinstate services, payment must be paid in full, including the late fee.

All transfers are subject to a $25.00 charge per session per transfer. If a refund is requested prior the beginning of the session for which they are enrolled, a 15% administration fee will be applied. **NO refunds will be granted once a session has begun.** No make-ups or credits will be given for missed days. **NO refunds for suspensions, for lice etc or expulsions.**

In the event of that my check should not clear, I also understand that I will not be accepted into any other programs and/or classes until this debt is paid in full.

I understand that the program will be closed and will not operate on all City Holidays. I further understand that the program will not pick up my child on "Pupil Free Days," Furlough Days, Staff Development Days, or any other day school is not in session. I understand there will be no pro-rated adjustments and/or credits or reduction of fees in any event and that the standard program fees will remain in effect. **[Parent Initial: _____]**

I understand that in the event I anticipate picking up my child from school, I must notify the ASC office no later than 1:00 p.m. prior to picking up my child. There will be a $10.00 charge for no call no shows. To avoid this charge, please call 213.240.3006 or e-mail echopark.rc@lacity.org, before 1:00pm to inform us if your child will be absent or change in schedule. If the office does not receive the information before 1:00pm, a charge will occur. **[Parent Initial: _____]**

I understand that due to upcoming changes in the Department, program days and hours may be subject to change. **[Parent Initial: _____]**

Parent/Guardian Signature: _____ Date: _____

PAYMENT HISTORY

(FOR OFFICE USE ONLY)

August 2018	$ 95	Receipt #: _____	Processed by: _____	Date:_____
September 2018	$185	Receipt #: _____	Processed by: _____	Date:_____
October 2018	$185	Receipt #: _____	Processed by: _____	Date:_____
November 2018	$150	Receipt #: _____	Processed by: _____	Date:_____
December 2018	$115	Receipt #: _____	Processed by: _____	Date:_____
January 2019	$160	Receipt #: _____	Processed by: _____	Date:_____
February 2019	$175	Receipt #: _____	Processed by: _____	Date:_____
March 2019	$185	Receipt #: _____	Processed by: _____	Date:_____
April 2019	$150	Receipt #: _____	Processed by: _____	Date:_____
May 2019	$185	Receipt #: _____	Processed by: _____	Date:_____
June 2019	$ 65	Receipt #: _____	Processed by: _____	Date:_____