



# 2018 COUNSELOR LEADERSHIP PROGRAM



**Camper's Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_  
 Birth Date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Gender \_\_\_ School Name \_\_\_\_\_ T-Shirt Size \_\_\_\_\_

**Camper's Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_  
 Birth Date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Gender \_\_\_ School Name \_\_\_\_\_ T-Shirt Size \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

**Parent's Name** \_\_\_\_\_ Cell Phone \_\_\_\_\_ Cell Provider \_\_\_\_\_  
 Work Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

**Parent's Name** \_\_\_\_\_ Cell Phone \_\_\_\_\_ Cell Provider \_\_\_\_\_  
 Work Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

### AUTHORIZED PICKUP

Emergency Contact \_\_\_\_\_ Emergency Phone ( ) \_\_\_\_\_

I authorize only these additional people to pick up my children):

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
 Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
 Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

### RECOMENDATIONS AND RESTRICTIONS WHILE AT CAMP

Does your child have any conditions that would prevent him/her from participating in any camp activities:

Allergies (Foods, Nuts, Drugs, Bee Stings, Etc.) \_\_\_\_\_

Asthma or Hay Fever: \_\_\_\_\_

Does the camper take medication at present: \_\_\_\_\_

**\*\*\*If medication is to be given during camp, please contact the office.**

**Dietary Restrictions:**  Kosher  Gluten-Free  Lactose Intolerant  Peanut Free  Other \_\_\_\_\_

### Health Care Information

Insurance Provider: \_\_\_\_\_ Policy #: \_\_\_\_\_

Doctor Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Additional Medical Information: \_\_\_\_\_

SESSION	EARLY BIRD (3/19-4/21/18)	REGULAR (4/22-8/10/18)	TOTAL	RECEIPT #	STAFF INT.	NOTES
1	\$60	\$70				<input type="checkbox"/> T-SHIRT _____
2	\$60	\$70				<input type="checkbox"/> EMERGENCY CARD
3	\$60	\$70				<input type="checkbox"/> PARENT HANDBOOK
4	\$50	\$60				<input type="checkbox"/> CLP HANDBOOK
5	\$60	\$70				<input type="checkbox"/> CLP TRAINING
6	\$60	\$70				
7	\$60	\$70				
8	\$60	\$70				
9	\$60	\$70				HH# _____

**Year Round Camp Registration Fee**

**\$35**

**Payment Plan**

YES  NO



# POLICIES AND PROCEDURES



**Please read carefully before you sign:**

Campers must be signed into and out of camp and extended care daily by a person who has been authorized by you. Any person authorized to pick up must have their name on file with the Recreation Center and be prepared to show I.D. Echo Park Recreation Complex is not responsible for children before or after day camp unless they are currently enrolled in Extended Care. Written permission must be provided if you wish your child to be released to anyone other than those authorized on the registration form. We will check identification.

Campers who are not signed out by 6:00 p.m. will be placed in the recreation center office and charged a late fee of \$10.00 for every 15 minutes or part thereof. This applies to all children unless they have written parental permission (see below) to sign themselves out of camp. Children in Preschool Camp who are not picked up within 15 minutes of camp ending for the day will be charged \$10 for every 15 minutes or part thereof.

I understand that my child must wear the appropriate Camp Shirt on Field Trip Days. Children not wearing the proper shirt will be given one and charged \$10.00. I understand that all children must ride the charter bus to the field trips provided by the Recreation Center. There will be NO drop-offs or pick-ups at the trip sites. **NO EXCEPTIONS.** Staff is not responsible for lost or stolen items. Please write your child's name on their belongings.

I acknowledge that I have read the 2018-2019 Summer Camp Brochure and Parent Information Packet. I understand and agree to all terms and requirements.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

## CANCELLATION & TRANSFER PROCEDURES

All transfers are subject to a \$20.00 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 or expulsions.**

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

## PERMISSION TO SIGN IN AND OUT OF CAMP (ONLY FOR AGE 9 AND UP)

Please be aware that by giving permission for your child to sign in and/or out of camp, the staff and recreation center are in no way responsible for your child until he/she signs in with a counselor.

**Circle One:**

**YES NO** My child has permission to sign him/herself INTO camp.

**YES NO** My child has permission to sign him/herself OUT of camp.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

## PARENTAL CONSENT

I give permission for my child \_\_\_\_\_ to participate in the Echo Park Recreation Complex Camp Fun Chasers programs, including field trips by chartered bus. I agree to hold harmless the City of Los Angeles, Department of Recreation and Parks and its officials, agents/employees for injury to my child as a result of participation in Day Camps. I understand that the park nor the Department of Recreation and Parks carries insurance. I also understand that any camper who does not cooperate with camp staff will lose privileges to activities and can be expelled from camp.

I, the undersigned parent(s) of \_\_\_\_\_, do authorize Echo Park Recreation Complex as agent for the undersigned to consent to 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 specialized supervision of any physician licensed under the provision of the Medical Practice Act on the staff of a licensed hospital, whether such diagnoses or treatment is rendered at the office of said physician or at said hospital.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

## PHOTO RELEASE

The City of Los Angeles' Department of Recreation and Parks or its assigned agents has my permission to use images (digital, film, tape, or video) of my child \_\_\_\_\_ (minor's name) and/or myself for promotion of Echo Park Recreation Complex program

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

## MOVIES

**YES NO** My child has permission to watch G or PG movies during Quiet Time (alternate activities available)

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_



# HEALTH HISTORY FORM—SUMMER 2018



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

CAMPER NAME: \_\_\_\_\_

MALE  FEMALE Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/ Legal Guardian (name): \_\_\_\_\_ Phone #: \_\_\_\_\_

Doctor (name): \_\_\_\_\_ Phone #: \_\_\_\_\_

Has the camper had the following (please check all that apply):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Chicken Pox     | <input type="checkbox"/> Sinus Trouble  | <input type="checkbox"/> Fainting      |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Tonsillitis    | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> German Measles  | <input type="checkbox"/> Appendicitis   | <input type="checkbox"/> Stomch Upset  |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Skin Rash     |
| <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Hay Fever      | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> Diphtheria      | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Nosebleeds    |
| <input type="checkbox"/> Heart Trouble   | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Mumps           | <input type="checkbox"/> 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 of the camp and feel the camper can participate without restrictions.
- I have reviewed the program and activities of the camp and feel the camper can participarte 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

The following non-prescriptions may be stocked at camp and are used as an as needed basis to manage illness and injury. Check the box if the camp may be given the following or its generic form.  Neosporin  Sunscreen

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_



**REQUEST FOR MEDICATION TO BE GIVEN DURING CAMP**



I request that my child, \_\_\_\_\_, be monitor/allowed to take the following prescribed medicine (s) while at camp. I understand that staff of Echo Park Recreation Complex will only give the medicine described below according to the time, dosage and frequency indicated on the pharmacy label of the medicine bottle. "Medication" is any substance a person takes to maintain and/or improve health. This includes vitamin & natural remedies. All medications **must be original pharmacy containers with labels**, no modifications. Please provide enough of each medication to last the entire time the camper will be at camp.

Name of Medicine: \_\_\_\_\_ # of Pills \_\_\_\_\_ Date Started \_\_\_\_\_

When is it given:   Breakfast   Lunch   Dinner   Bedtime   Other \_\_\_\_\_

Amount of Dose Given: \_\_\_\_\_ How is it given: \_\_\_\_\_

Resons 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: \_\_\_\_\_

Resons 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: \_\_\_\_\_

Resons for taking Medicine: \_\_\_\_\_

**Signature of Parent/Guardian** \_\_\_\_\_ **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 herby authorize the directors of Echo Park Recreation Complex 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 liscensed 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 judgement may deem advisable. This authorization shall remain effective through the conclusion of the event, unless sooner revoked in wirting and delivered to said agent(s).

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_