2019-2020 Pre-School Program

PARK PROUD LA

Queen Anne Recreation Center

1. CHILD'S Last Name_____ **First Name**_____

Birth Date____/_____/____ Age_____Gender ____ School Name _____T-Shirt Size_____

2. CHILD'S Last Name_____ **First Name**_____

Birth Date____/_____/____ Age_____Gender ____ School Name _____T-Shirt Size_____

Address_____ City_____ Zip_____

1. PARENT/GUARDIAN'S Name_____Cell Phone_____

Work Phone _____E-Mail_____

2. PARENT/GUARDIAN'S Name_____Cell Phone_____

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 PROGRAM

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

_____

Allergies (Foods, Nuts, Drugs, Bee Stings, Etc. _____

Asthma or Hay Fever: _____

Does your child take medication at present:_____

***If medication is to be given during the program, 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	TOTAL	RECEIPT #	SESSION	TOTAL	RECEIPT #	NOTES
AUG	$65.00		MAY	$65.00		
SEP	$65.00		JUNE	$20.00		
OCT	$65.00					
NOV	$65.00					
DEC	$65.00					
JAN	$65.00					
FEB	$65.00					
MAR	$65.00					
APR	$55.00					HH#_____

PSC Registration Fee $20.00

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CANCELLATION & TRANSFER PROCEDURES

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 or expulsions.**

Signature of Parent/Guardian _____ **Date**_____

PERMISSION TO SIGN IN AND OUT OF PROGRAM

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

Circle One:

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

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

Signature of Parent/Guardian _____ **Date**_____

PARENTAL CONSENT

I give permission for my child _____to participate in the Queen Anne Recreation Pre School 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 PSC Program. I understand that the park nor the Department of Recreation and Parks carries insurance. I also understand that any child who does not cooperate with program staff will lose privileges to activities and can be expelled from PSC program.

I, the undersigned parent(s) of _____, do authorize Queen Anne Recreation Center 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 Queen Anne Recreation Center 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 Pre-School Program 2019

Note: Should anything happen to your child that would alter his health history information after this form is retuned, and before arrival at program, please let the office know immediately.

CHILD'S NAME:_____

I Identify As:_____Birth Date:_____ Age:_____

Address:_____

City:_____State:_____Zip:_____

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

Doctor (name):_____Phone #:_____

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

□ Chicken Pox	□ Sinus Trouble	□ Fainting
□ Measles	□ Tonsillitis	□ Constipation
□ German Measles	□ Appendicitis	□ Stomch 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 of the program and feel my child can participate without restrictions.

☐ I have reviewed the program and activities of the program and feel my child 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 your child received medical treatment during the past year? ☐ YES or ☐ NO
Date:_____Reason: _____

Is your child taking any medications now? ☐YES or ☐NO

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

Signature of Parent/Guardian _____ **Date**_____

REQUEST FOR MEDICATION TO BE GIVEN DURING PROGRAM

I request that my child, _____, be monitor/allowed to take the following prescribed medicine (s) while at PSC program. I understand that staff of Queen Anne Recreation Center 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 your child will be at PSC 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:_____

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 Queen Anne Recreation Center 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 specfic consent to any and all such diagnosis, treatment or hospital care which the aforementationed 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**_____