



2019-2020 After School Program



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 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 #: _____

SESSION	TOTAL	RECEIPT#	TOTAL	SESSION	RECEIPT#	NOTES
AUG	\$65.00		MAY	\$65.00		HH# _____
SEP	\$65.00		JUN	\$20.00		
OCT	\$65.00					
NOV	\$65.00					
DEC	\$65.00					
JAN	\$65.00					
FEB	\$65.00					
MAR	\$65.00					
APR	\$55.00					

ASC Registration Fee

\$20.00



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 CAMP

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 Queen Anne Recreation Camp Whatever 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 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 After School Program 2019



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

Child's NAME: _____

I Identify As: _____ 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 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

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 PROGRAM



PARKPROUDLA I request that my child, _____, be monitor/allowed to take the following prescribed medicine (s) while at camp. 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 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** _____

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 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** _____