SEOUL INTERNATIONAL PARK
AFTERSCHOOL CLUB - EMERGENCY INFORMATION

CHILD'S NAME_____ _____D.O.B_____Age_____ M / F_____
LAST FIRST

SCHOOL ATTENDING: _____

MOTHER'S NAME_____HM PHONE(_____)_____

ADDRESS_____WK PHONE(_____)_____

FATHER'S NAME_____HM PHONE(_____)_____

ADDRESS_____WK PHONE(_____)_____

IN AN EMERGENCY, IF PARENTS ARE UNAVAILABLE, CONTACT:

NAME_____RELATIONSHIP_____

HM PHONE(_____)_____WK PHONE(_____)_____

NAME _____RELATIONSHIP_____

HM PHONE(_____)_____WK PHONE(_____)_____

Parental Permission Consent and Agreement

By registering for this program I understand the City of Los Angeles, Department of Recreation and Parks **carries no insurance** for my child. I further agree to relieve Seoul International Park 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 from this facility.

I understand that there is no care on school holidays or on city holidays.
I understand that each child is expected to partake in all activities in which they are physically able.
I understand that any child or parent who does not cooperate with park staff will be expelled from the program without a refund.
I authorize the use of my child's image or likeness for distribution in park related promotional materials.
I understand that a $1 per minute late pick up fee per child will be assessed if the child is picked up after the end of the regular program hours.
I understand that I will need to call the park if my child is going to be absent from the program.
I understand that I will be charged a $5 return trip fee if staff needs to return to the school to pick up my child who did not meet the staff at the appointed time or place.

Signature of Parent or Guardian: _____ Date: _____

If at any time information on this application changes, Please notify the Director in writing immediately.

HEALTH HISTORY FORM

Child's Name : _____

Medical Plan (Insurance) : _____

Dates of Last Immunizations: Polio _____ Diptheria _____ Whooping Cough _____ Tetanus____

Please list any medical conditions, restrictions or special needs: _____

_____

Allergies: _____ Operations / Serious Injures _____

Has child received medical treatment during the past year? (Y/N) _____
If yes, Date _____ Reason _____

Does child take any medication at present?* (Y/N) _____If so, What ?_____

Can your Child be given*: Tylenol _____ Pepto Bismol _____ Benadryl _____

***NOTE-** Seoul International Park Staff will not be responsible for administering any medication – There will be NO EXCEPTIONS!

HAS YOUR CHILD HAD THE FOLLOWING:

Chicken Pox_____	Rheumatic Fever _____	Measles _____	German Measles _____
Mumps _____	Scarlet Fever _____	Appendicitis_____	Diphtheria_____
Asthma_____	Heart Trouble_____	Tonsillitis_____	Sinus Trouble_____
Ear Infection_____	Colds _____	Hay Fever _____	Headaches _____
Fainting _____	Constipation _____	Stomach Upset _____	Skin Rash _____
Nosebleeds_____	Other: _____		

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

(I) (We), the undersigned parent(s)/guardian(s) of _____ a minor, do herby authorize the PARK REPRESENTATIVES as agents(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 Medicine 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 our aforesaid agent(s) to give specific diagnosis, treatment or hospital care which the aforementioned physician, in the exercise of his/her best judgment, may deem advisable.

This authorization shall remain effective until _____unless sooner revoked in writing and delivered to said agent(s).

_____	_____	_____
DATE	PARENT/ GUARDIAN NAME	PARENT/ GUARDIAN SIGNATURE

Preferred Hospital_____
Name Address Phone

Doctor's Name_____

CHECK OUT INFORMATION

Parent/ Guardian please fill out the information below. Please type or print legibly.

CHILD'S NAME_____ D.O.B_____ Age_____

ONLY THE FOLLOWING INDIVUDALS ARE AUTHORIZED TO PICK UP MY CHILD.

PLEASE INCLUDE YOURSELF AND ANY OTHER APPLICABLE PERSONS (i.e. MOTHER, FATHER, SIBLINGS, ETC.)

CHILDREN WILL NOT BE RELEASED TO ANY ADULT UNLESS THEY ARE LISTED ON THIS FORM.

NAME _____ RELATIONSHIP_____

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NAME _____ RELATIONSHIP_____

NAME _____ RELATIONSHIP_____

NAME _____ RELATIONSHIP_____

NAME _____ RELATIONSHIP_____

Is there anyone who is specifically **NOT** to pick up the child:

_____

_____