City of Los Angeles - Department of Recreation and Parks
STATE STREET RECREATION CENTER

# Afterschool Club Registration Form 2019-20

## PARTICIPANT INFORMATION

Participant's Last Name:_____ First Name:_____ M F Birthday:____/_____/____ Age: ___

School:_____ Grade:_____ Room #_____ Teacher's Name_____

## PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian Name:_____ Email: _____

Address:_____ City_____ Zip Code_____

Cell Phone: (____)_____ Home Phone: (____)_____ Work Phone: (____)_____

Parent/Guardian Name:_____ Email: _____

Address:_____ City_____ Zip Code_____

Cell Phone: (____)_____ Home Phone: (____)_____ Work Phone: (____)_____

## PERSON(S) TO CONTACT IN CASE OF EMERGENCY, if I cannot be reached:

Name:_____ Phone Number: (_____)_____ Relationship _____

Name:_____ Phone Number: (_____)_____ Relationship _____

## Only the following individuals are authorized to pick my child up:

Name: _____ Phone_____ Relationship _____

Name: _____ Phone_____ Relationship _____

Name: _____ Phone_____ Relationship _____

Name: _____ Phone_____ Relationship _____

Name: _____ Phone_____ Relationship _____

**Parent/Guardian Name:**_____**Signature:**_____**Date:**____/_____/____

WAIVER RELEASE

AGREEMENT ASSUMING RISK OF INJURY OR DAMAGE, WAIVER AND RELEASE OF CLAIMS AND AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR IN CASE OF EMERGENCY, ILLNESS, OR ACCIDENT

I hereby authorize my son/daughter _____ to travel (bus, van or walking) to any field trip/outing/school pickup/ bus stop pick up in association with STATE STREET RECREATION CENTER, including walking from school with staff to State Street Recreation Center after School Club. I release the City of Los Angeles and its officials, agents, and employees from any liability in connection with this authorization.

(I)/ (We), the undersigned parent (s) of _____, a minor, do hereby authorize the **DIRECTORS AND STAFF OF _____ 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 specific supervision of any physician (M.D.), dentist (D.D.S.) or surgeon licensed under the provision of the Medical 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 said hospital. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of my dependent. **CALIFORNIA SECTION 25.8 CIVIC CODE**

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care that may be required, and 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 aforementioned physician in the exercise of his/her best judgment may deem advisable. I further relieve the Department of Recreation and Parks, City of Los Angeles, and its officers, agents or employees of any liability in connection with this request.

I am aware that there are certain risks of injury and/or damage inherent in the Program activities.

I understand that if my child misbehaves and/or is sick and needs to be sent home, I agree to pick her/him up at the time requested by ASC staff.
I agree to complete the camp health history form providing Minor's current, complete and truthful health history, including immunization history and overall physical, mental and emotional health status. Under certain medical conditions, I understand that State Street Recreation Center may require a written authorization based on a physical examination by a licensed medical person as a requirement for the Minor to participate in the Program. To the best of my knowledge and belief, Minor is not subject to a physical or mental infirmity or under the influence of any medication or other substance which might hinder his/her safe participation in the program.

I will instruct Minor to abide by all safety regulations and to take reasonable precautions to minimize the risks of injury or damage arising from participation in the Program.

I give my consent to have Minor participate in all aspects of the Program and I knowingly assume full responsibility for all risks of bodily injury, death or property damage which Minor may sustain as a result.

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 also authorize the City to make, procure or use photographs, films, tapes or other likenesses of Minor's physical image and/or voice as may be needed for use with Program's publicity materials.

Except for the gross negligence or willful misconduct of the City, I waive all rights of recovery which Minor or I may have now or in the future, whether known or unknown, against the City of Los Angeles or its officers, agencies or employees, and I release, acquit and forever discharge the City from any and all liability for any bodily injury or other personal injury, damage, loss or expense, claims, demands, causes of action, money damages, costs, loss of services or use, compensation, debts, including attorney fees, which result from or are in any way connected with Minor's participation in the Program or any related activities.

I have carefully read this agreement. I understand what it means and my signature below is my own free act. I intend it to be legally binding on Minor and myself. I also acknowledge that I have received the ASC Rules and Procedures and agree to the terms and policies described therein.

THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNTIL REVOKED IN WRITING AND DELIVERED TO SAID AGENT(S).

**DATE:** _____ **PARENT OR GUARDIAN SIGNATURE:** _____

**DATE:** _____ **PARENT OR GUARDIAN SIGNATURE:** _____

**HEALTH BACKGROUND INFORMATION**

Participant's Last Name:_____ First Name:_____ M F Birthday:____/_____/____ Age: ___

Current Tetanus Shot: Yes No

**Has the child had the following:**

| | | |
|---|---|---|
| Chicken Pox _____ | Rheumatic Fever _____ | Measles _____ |
| Sinus Trouble _____ | Mumps _____ | Colds _____ |
| Headaches _____ | German Measles _____ | Fainting _____ |
| Ear Infections _____ | Asthma _____ | Tonsillitis _____ |
| Constipation _____ | Upset Stomach _____ | Appendicitis _____ |
| Scarlet Fever _____ | Diphtheria _____ | Heart Trouble _____ |
| Hay Fever _____ | Skin Rash _____ | Nose Bleeds _____ |

Other: _____

**Comments:** _____

**Allergic Reactions Please List:**
Food(s): _____

Bee Sting (etc.): _____

Drugs/medications (penicillin, etc.):_____

**Operations or serious injuries:** _____

Has the child received medical treatment in the past year? _____ If yes, please provide the date and reason for treatment._____
_____
_____

Does the child take any medication presently? _____ If yes, please list them, specific dosage and amounts daily.

| **Medication | Dosage (1 pill, half pill etc.) | Times Daily (1 time, with food etc.) |
|---|---|---|
| 1._____ | _____ | _____ |
| 2._____ | _____ | _____ |
| 3._____ | _____ | _____ |

Medical Provider: _____ Doctors Name:_____

**We are not allowed to administer medication. Participant must be able to self administer medications. (Open and close container, take meds etc…without staff assistance.)