City of Los Angeles
Department of Recreation and Parks

VINEYARD RECREATION CENTER

Afterschool Club Registration Form

PARTICIPANT INFORMATION

Participant's Last Name:_____ First Name:_____ M F

Address:_____ City_____ Zip Code_____

Birthday: _____/_____/_____ Age: _____ School:_____ Grade:_____

Teacher Name _____ Room#_____

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian Name:_____

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

E-mail:_____@_____

Parent's Name:_____

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

E-mail:_____@_____

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:____/_____/____

PARENT/GUARDIAN PERMISSION:

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 VINEYARD RECREATION CENTER, including walking from school with staff to Vineyard Recreation Center. I release the City of Los Angeles and its officials, agents, and employees from any liability in connection with this authorization.

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

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR IN CASE OF EMERGENCY, ILLNESS, OR ACCIDENT

(I) / (We), the undersigned parent (s) of _____, a minor, do hereby authorize the **DIRECTORS AND STAFF OF VINEYARD 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.

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

DATED: _____ **PARENT OR GUARDIAN SIGNATURE:** _____

Participant's Last Name: _____ First Name: _____

HEALTH BACKGROUND INFORMATION

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._____	_____	_____

**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.)