



ARTS ALIVE CAMP

EMERGENCY FORM

PLEASE RETURN THE FIRST DAY OF CLASS!

Please print and fill out the form completely!

Participant Name: _____

Address (including town & zip): _____

Primary Phone: _____ Age: _____

Father's Name: _____ Mother's Name: _____

Father's Work: _____ Mother's Work: _____

Alternate Emergency Contact: _____ Phone #: _____

Carpooling: We understand that your child's friends maybe enrolled in the same class. Keeping this in mind, the staff would appreciate the names and numbers of individuals who will be picking up your child for safety reasons. Please include the names and phone numbers of any grandparents or other individuals who might be picking up your child as well.

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Medical allergies, illness or other condition: _____

Please fill out medication form on the back if needed.

The Arlington Heights Park District welcomes all participants into programs. Please describe any special accommodations needed for successful participation.

- OVER -

PLEASE CHECK:
My Child is in...
Session I: _____
Session II: _____



THIS SIDE IS ONLY NEEDED IF YOUR CHILD IS BRINGING MEDICATION TO CAMP

Request and Waiver to Administer a Prescription Medication

If your child has a medical condition that may require medication during our program, please fill out this form.

Name of Child: _____

Program: _____ Location: _____

Parent/Legal Guardian: _____ Phone Number: _____

Primary Doctor: _____ Phone Number: _____

Condition requiring medication: _____

Medication Name: _____

Instructions: _____

Any special storage requirements:

WAIVER

I _____, myself/or the parent/guardian of _____ give permission to the staff of the Arlington Heights Park District to administer the above prescription medication to my child.

I understand that it is my responsibility to give the prescription medication directly to the Arlington Heights Park District staff in the original container, showing the prescribing physician's name and telephone number, with complete dosage requirements.

I agree to waive and relinquish all claims and do hereby fully and forever release and discharge the Arlington Heights Park District and its officers, agents, servants and employees from any and all claims I may have a result of administering a prescription medication for my child that I have specified in this request.

Signature: _____ Date: _____