Youth Activity Waiver

Child's Name:___________________________________

Date of Birth: ___________________________________

Original Enrollment Date: ___________________________

Parent/Guardian Name:_____________________________

Address: ____ Phone (1): ______________________
P.O. Box or Physical

____ Phone (2): ______________________
City State Zip

Email Address: ________________________________

I would like my email address added to the Youth Program's email list to keep me informed Yes ____ No___

Allergies: __________________________________ What grade will your child be in next year?____

Does your child have any past or present medical history that we should be made aware of?

____

The following individuals are authorized to pick up my child in my absence:

Name	Phone	Phone	Relationship
______________	______________	______________	______________
______________	______________	______________	______________

Personal Release

In consideration of the acceptance of my child's enrollment in all Town of Avon Programs, I for myself, my child, my executors, administrators, and assignees, do hereby waive any and all rights and claims I may have against the Town of Avon, its personnel , instructors, or other individuals associated with the recreational program, for any and all injuries, disabilities or death suffered by my child as a result of my participation in any recreational programs or activities conducted at or sponsored by the Avon Recreation Center. I also authorize and consent to any emergency medical treatment rendered to myself or child under the general or special supervision, on the advice of any physician.
Parent/Guardian Signature:____ Date: __________

Medical Release

In the event that you child may require medical attention and that parents/guardian or alternate contact person's named on this application cannot be contacted, Avon Recreation Center officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health of aforesaid child. I agree I am solely responsible for the payment of all costs resulting from the rendering of medical and ambulance services.
Parent/Guardian Signature:____ Date: __________

Transportation Authorization

My child has permission to be transported by the Town of Avon Recreation Department staff and personnel for the purpose of scheduled activities and field trips.
Parent/Guardian Signature:____ Date: __________

Sunscreen Waiver

I give employees of the Town of Avon Recreation Department permission to apply sunscreen that is provided by me to my own child on an as needed basis, as prescribed by the directions on the bottle. If I do not supply sunscreen, I will allow the Town of Avon employees to use their sunscreen on my child.
Parent/Guardian Signature:____ Date: __________

Movie Rating

My child may watch G-rated and PG-rated movies while at camp.
Parent/Guardian Signature:____ Date: __________

Photography Release

I give my permission to The Town of Avon to use photos or video segments of me or my family for promotional or publication purposes.
Parent/Guardian Signature:____ Date: __________

Cancelation Policy:	***Seven days prior to start of the day(s) registered:***	***No Refund***
	More than seven days prior to the day(s) registered:	***50% of the total amount paid***

Emergency Medical Information

Child's Name: ______________________________

Date of Birth: ______________________________

Immunization records received?
Yes: ____________ No: ____________

Date of Last Tetanus Shot: ______________________

Family Doctor	Insurance Company
Name: ____________________	Name: ____________________
Phone Number: ____________________	Policy Number: ____________________
Hospital	**Dentist**
Name: ____________________	Name: ____________________
Address: ____________________	Phone Number: ____________________

Parent/Guardian Name: ______________________ Relationship: ______________

Address: ______________________________ Phone (1): ______________
P.O. Box or Physical

______________________________ Phone (2): ______________
City State Zip

Does the child live with this Parent/Guardian? Yes __ No __ Phone (3): ______________

Parent/Guardian Name: ______________________ Relationship: ______________

Address: ______________________________ Phone (1): ______________
P.O. Box or Physical

______________________________ Phone (2): ______________
City State Zip

Does the child live with this Parent/Guardian? Yes __ No __ Phone (3): ______________

Parent Employer: ______________________ Phone: ______________

Address: ____

Emergency Contact: ______________________ Relationship: ______________

Phone (1): ______________________ Phone (2): ______________________

Emergency Contact: ______________________ Relationship: ______________

Phone (1): ______________________ Phone (2): ______________________

The Above information is correct and I give permission to the Town of Avon Recreation Department to release my child to those people listed above. I also realize that it is my responsibility to inform the Town of Avon Recreation Department <u>ANY TIME</u> the above information changes

Parent/Guardian Signature: ______________________________ **Date:** __________

General Health Appraisal

Completed by Health Care Professional

Child's Name: ________________________________

Date of Birth: ________________________________

Food or Drug Allergies: ________________________________

Type of Allergic Reactions: ____

Current Medications: ____

Special Dietary Requirements: ____

Does the child have a health care plan? _____ If yes, the health care plan must be provided on or before the first day the child is in care.

Is the child fully immunized? ______ Completed Immunization records must be provided within 30 days of child's enrollment.

Describe any Chronic Medical Conditions such as asthma, seizures, ear infections, diabetes, illness, hospitalization or concerns with development that child care provider(s) need to be aware of. NONE: ___________

____

____

____

Additional comments including instructions to child care providers(s). NONE: ___________

____

____

____

Date of most recent examination of child: ____________________

Note: must have been completed within the last 12 months

Weight: ___________ Height: ____________ Vision: ____________ Hearing: ___________

Dental Screening: ______________ Immunization given or attached immunization record: __________

Acetaminophen (Tylenol) _______________ may be given for fever over 102° or pain every 4 hours as needed.

(Amount) *Note: No more than a 3 day period, without medical authorization*

Health Provider's Name: ______________________________________ **Date:** __________________

Health Provider's Signature: ___________________________________ **Phone:** ________________

Health Providers Address: ____________________________________

____

I give consent for my child's health care provider(s) and child care provider(s) to discuss my child's health.
Parent/Guardian Signature: ____ **Date:** ___________

Allergy and Anaphylaxis Action Plan and Medication Orders

Student's Name: ______________________ D.O.B. ________ Grade: ________
School: ______________________ Teacher: ______________________

Place child's photo here

ALLERGY TO: ______________________

History: ______________________

Asthma: ☐ YES (Higher risk for severe reaction) ☐ NO

◊ STEP 1: TREATMENT ◊

SEVERE SYMPTOMS:
One or more of the following:
- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Obstructive swelling (tongue and/or lips)
- SKIN: Many hives over body

Or **combination** of symptoms from different body areas:
- SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
- GUT: Vomiting, crampy pain

→

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   - Antihistamine
   - Inhaler (quick relief) if asthma

*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE

☐ **Give epinephrine immediately if the allergen was definitely ingested, even if there are no symptoms**

MILD SYMPTOMS ONLY:
- MOUTH: Itchy mouth
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/discomfort

→

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring

DOSAGE

Epinephrine: inject intramuscularly using auto-injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ Administer 2nd dose if symptoms do not improve in ____________ minutes

Antihistamine: (brand and dose) ______________________

If Asthmatic: (brand and dose) ______________________

Student has been instructed and is capable of carrying and self-administering own medication. ☐ Yes ☐ No

Provider (print) ______________________ Phone Number: ____________

Provider's Signature: ______________________ Date: ____________

If this condition warrants meal accommodations from food service, please complete the medical statement for dietary disability

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: ______________________ Phone Number: ______________________
3. Emergency contacts: Name/Relationship Phone Number(s)
   a. ______________________ 1) ____________ 2) ____________
   b. ______________________ 1) ____________ 2) ____________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: ______________________ Date: ____________

School Nurse: ______________________ Date: ____________

Actividades de Jovenes

Nombre del Niño/a:______________________________

Fecha de Nacimiento: ______________________________

Dia Orginal de Inscripcion: ______________________________

Nombre de Padres/Guardia:______________________________

Direcion: ______________________________ Telefono (1): ____________________

P.O. Box or Fisico

______________________________ Telefono (2): ____________________

Ciudad Estado Codigo

Correo Electronico: ______________________________

Me gustaria tener mi correo electronico en la lista del programa juvenile, para estar informadol(a) Si_____ No ______

Alergias: ______________________________ En qué grado será su hijo estará en el próximo año? ______

Su hijo tiene problemas medicos o en el pasado haiga tenido, que sea importante saver?

____

Las personas que tengan autorizacion de recojer al nino/a en su ausencia:

Nombre	Telefono	Telefono	Relacion
________	________	________	________
________	________	________	________

Liberacion Personal

En consideracion que accepten a mi hijo/a en los Programas de La Ciudad de Avon, Yo por mi, mi hijo/a, mi cesionario y administradores por este medio renuncio cualquier y todos mis derechos y reclamos que pueda tener con La Ciudad de Avon, y su personal, Instructores, y otros individuales que esten relacionados con el programa y el centro de recreacion. Por cualquier leccion, desabilidad o muerte que pueda sufrir mi hijo/a en resultado de cualquier actividad, o programa que sea de parte de Centro de Recreacion de Avon. Autorizo y doy mi consentimiento que cualquier emergencia medica o tratamiento necesario a mi o a mi hijo/a debajo de supervicion de un medico.

Firma Padre/Guardian:______________________________ Fecha: _________

Liberacion Medico

En el evento que mi hijo/a necesite asistencia medica y los padres, guardianes y persona de autorizadas (Personas de permiso para recojer) no esten presentes o encontrados. Recreacion de Avon y sus officiales, doy permiso ah que ellos tomar decision a cualquier accion nesesaria debajo de su juicio del estado medico de mi hijo/a. Yo estoy de Acuerdo y soy responsable de cualquier pago medico o de abulancia si necesario para mi hijo/a.

Firma Padre/Guardian:______________________________ Fecha: _________

Autorizacion de Transporte

Mi hijo/a tiene mi permiso de ser transportado por los empleados del Recracion de Avon, En situaciones de programas o dias de campo.

Firma Padre/Guardian:______________________________ Fecha: _________

Renuncia de Protector Solar

Yo les doy permiso a los Empleados de la Ciudad de Avon del departamento de Recreacion, Yo personalmente le pondre a mi hijo/a antes del programa o yo tender protector solar para que se use cuando nesesario. Y el empleado tiene mi permisso de ponerselo y si acaso yo no tengo ellos pueden usar el que tenga el programa.

Firma Padre/Guardian:______________________________ Fecha: _________

Clasificacion de Pelicula

Mi hijo/a puede ver peliculas que esten clasificadas G o PG mientras esten en campamento

Firma Padre/Guardian______________________________ Fecha: _________

Fotografía de Lanzamiento

Doy permiso a la ciudad de Avon para usar fotos o segmentos de video de mí o mi familia para fines promocionales o de publicación .

Firma Padre/Guardian______________________________ Fecha: _________

Poliza de Cancelaccion: *7 dias antes de empezar el dia(s) que estan registrados:* ***No Reembolosos***

Mas de 7 dias anterior de los dias registrados: ***50%del pago total***

Informacion Medica para Emergencias

Nombre del Nino:___________________________________

Fecha de Nacimiento: ______________________________

Cartilla de Vacunas Recivido?
Si: _______________No: _____________

Ultima fecha de vacuna para Tetanos: __________________

Doctor de Famila	**Aseguranza**
Nombre: ________________________________	Nombre: ________________________________
Numero de Telefono: ______________________	Numero de poliza: ________________________
Hospital	**Dentista**
Nombre: ________________________________	Nombre: ________________________________
Direccion: _______________________________	Numero de Telefono: _____________________

Padre/Guardian:_______________________________ Relaccion: ______________________________

Direccion: ____Telefono (1): _______________________
P.O. Box o Fisico

____ Telefono (2): _______________________
Ciudad Estado Codigo

Su hijo/a Vive con el/la Guardian? Si ___ No __ Telefono (3): ______________________________

Padre/Guardian:_______________________________ Relaccion: ______________________________

Direccion: ____Telefono (1): _______________________
P.O. Box o Fisico

____Telefono(2): ________________________
Ciudad Estado Codigo

Su Hijo/a Vive con el/la Guardian? Si____ No __ Telefono (3): ____________________________

Padre/Guardian Empleador :__________________________ Telefono: _________________________

Direccion: ____

Contacto de Emergencia:___________________________________ Relaccion: __________________

Telefono (1): _____________________________Telefono (2): __________________________________

Contacto de Emergencia:___________________________________Relaccion:__________________

Telefono (1): _____________________________ Telefono (2): __________________________________

La Informacion de arriba esta correcta y doy mi permiso a la Ciudad de Avon el departamento de Recreacion Liberar hijo/a con la gente en la lista que di.

Padre/Guardian: ____ **Fecha:** ___________

Evaluacion de Salud General

Completado por un Doctor Professional

Nombre del Nino/a:________________________________

Fecha de Nacimiento: ______________________________

Alergias a comidas o Medicinas: ______________________________

Tipo de Reaccion Alergias: ____

Medicamentos Corrientes: ____

Necesidades Dieteticas especiales: ____

Su hijo/a tiene seguro medico? __________ Y si lo tiene, el seguro medico tiene que aver sido usado antes del primer dia de campamento.

Tiene las vacunas nesesarias? __________ Cartilla de Vaccunacion a de ser entregada 30 dias antes de entrar al programa.

Describa condiciones Medicas Cronicas por ejemplo Asthma, Conbulciones, Infeccion de oido, Diabetis, Infecciones, Razones for estar en el hospital. O alguana duda que tenga de la salud de su hijo/a. Ninguno: ____

____

____

____

Comentarios o Instruciones acerca de su hijo/a para el personal, que estara con su hijo/a. Ninguno: ____

____

____

____

Fecha del mas reciente examen de su hijo/a: ______________________

Nota: Deve de ser completado de los ultimos 12 meses

Peso: ______ Altura: ______ Vision: ____________ Audicion: __________

Deteccion Dental: _______________ Vaccunacion o agrege la cartilla de Vaccunas: __________

Acetaminophen (Tylenol) _______________ Puede ser dado para fiebres arriba de 102 o para dolor cada 4 horas.
(cuantot) *Nota: No mas del period de 3 dias, sin autorizacion del medico*

Nombre de la Clinica: ____ **Fecha:** _________________

Nombre del Doctor: ____ **Telefono:** _______________

Direccion de La Clinica: ______________________________________

____

Doy mi Permiso a la clinica dar informaccion al personal del campamento sobre mi hijo/a

Firma Padre/Guardian: ____ **Fecha:** ___________

Allergy and Anaphylaxis Action Plan and Medication Orders

Place child's photo here

Student's Name: ______________________ D.O.B. ________ Grade: __________

School: ______________________ Teacher: ______________________

ALLERGY TO: ______________________

History: ______________________

Asthma: ☐ YES (Higher risk for severe reaction) ☐ NO

◊ STEP 1: TREATMENT ◊

SEVERE SYMPTOMS:

One or more of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Obstructive swelling (tongue and/or lips)
- SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

- SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
- GUT: Vomiting, crampy pain

→

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   - Antihistamine
   - Inhaler (quick relief) if asthma

*Antihistamine & quick relief inhalers are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE

☐ **Give epinephrine immediately if the allergen was definitely ingested, even if there are no symptoms**

MILD SYMPTOMS ONLY:

- MOUTH: Itchy mouth
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/discomfort

→

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring

DOSAGE

Epinephrine: inject intramuscularly using auto-injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ Administer 2nd dose if symptoms do not improve in ____________ minutes

Antihistamine: (brand and dose) ______________________

If Asthmatic: (brand and dose) ______________________

Student has been instructed and is capable of carrying and self-administering own medication. ☐ Yes ☐ No

Provider (print) ______________________ Phone Number: __________

Provider's Signature: ______________________ Date: __________

If this condition warrants meal accommodations from food service, please complete the medical statement for dietary disability

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: ______________________ Phone Number: ______________________
3. Emergency contacts: Name/Relationship Phone Number(s)
   a. ______________________ 1) __________ 2) __________
   b. ______________________ 1) __________ 2) __________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: ______________________ Date: __________

School Nurse: ______________________ Date: __________