WAUCONDA PARK DISTRICT
PARTICIPATION INFORMATION FORM
2017/2018 SCHOOL YEAR

Child's Name _____ Birth Date _____ Age _____
Address _____ City _____ Zip _____

Home Phone _____ Grade_____ Parents Email:_____

School _____Matthews Middle School _____Robert Crown

_____Wauconda Grade School _____Wauconda Middle School

Mother's Name _____ Occupation _____
Name of Business _____ Business Address _____
Bus. Phone _____Cell Phone: _____Date of Birth:_____

Father's Name _____ Occupation _____
Name of Business _____ Business Address _____
Bus. Phone _____Cell Phone: _____Date of Birth:_____

Child's Physician _____Phone _____
Physician's address _____
Allergies: _____
_____
Food Restriction: _____
_____
_____
Physical Limitations: _____
_____
Please add any additional information you feel necessary for the club staff to adequately supervise your child._____
_____
_____
_____

PARENTS WILL BE THE FIRST ONES CALLED IF THERE IS AN EMERGENCY

Emergency Contact Persons (If parent cannot be reached)

	Name / Relationship	
1.	_____ / _____	Phone #_____
2.	_____ / _____	Phone #_____
3.	_____ / _____	Phone #_____
4.	_____ / _____	Phone #_____
5.	_____ / _____	Phone #_____

Persons authorized to pick up your child from club:

	Name / Relationship	
1.	_____ / _____	Phone #_____
2.	_____ / _____	Phone #_____
3.	_____ / _____	Phone #_____
4.	_____ / _____	Phone #_____
5.	_____ / _____	Phone #_____

WAUCONDA PARK DISTRICT
EMERGENCY TREATMENT AUTHORIZATION

EMERGENCY TREATMENT: A minor may not be treated, even in an emergency situation, except when, in the opinion of the attending physician, a life is in the balance. Written consent is required for all treatment given in any hospital emergency room/center. Consent of a parent or legal guardian is necessary for unmarried minors, women under 18, and men under 21 except in cases of extreme emergency.

TO WHOM IT MAY CONCERN: As a parent and/or legal guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the listed minor in the event of medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

The release form is completed and signed of my own free will with the purpose of authorizing medical treatment under emergency circumstances in my absence.

Signed: _____ Date: _____

Relationship: _____

CHILD CUSTODY INFORMATION

Please circle the appropriate answer to the following questions

Do you have legal custody of this child? YES NO
If no please read**

Are you the legal guardian of this child? YES NO
If no please read **

** IF THERE IS A CUSTODY ISSUE WITH ANY CHILD YOU HAVE REGISTERED WITH US, YOU MUST PROVIDE A COPY OF A COURT ORDER THAT PROVES TO US WHO HAS LEGAL CUSTODY OF THE CHILD(REN).

** IF YOU ARE IN THE MIDDLE OF A SEPERATION OR LEGAL PROCEEDINGS INVOLVING CUSTODY, WE WILL REQUIRE A LETTER SIGNED BY BOTH OF THE BIOLOGICAL PARENTS THAT STATES WHO IS AUTHORIZED TO PICK UP YOUR CHILD(REN), AND THAT WE MAY SPEAK TO EITHER PERSON REGARDING ISSUES INVOLVING THE CHILD(REN).

Club Rules and Regulations Acknowledgment of Manual Form

THIS FORM MUST BE SIGNED AND TURNED IN WITH YOUR CHILD'S REGISTRATION FORM PRIOR TO THE FIRST DAY OF SCHOOL,

I have read and fully understand the procedures, policies, rules and regulations outlined in the parent handbook that are required of me and my child(ren) while enrolled in a Wauconda Park District Club program. I am also aware that there are certain consequences that may affect me or my child(ren) for not following these policies and procedures.

Please initial each item where indicated and sign at bottom.

1. I understand the late payment fee described in detail in this handbook. _____ Parent initials

2. I understand the cancellation/change policy outlined in this handbook. _____ Parent initials

3. I have fully read and understand the Wauconda Park District Club program behavior policy. _____ Parent initials

4. I understand that only the people that I have listed on my pickup list will be allowed to take my child from the Wauconda Park District program. _____ Parent initials

5. I have read the payment section; I understand that club needs to be paid by the 1st of every month. _____ Parent initials

_____
Parent or Guardian name (please print)

_____ _____
Signature of Parent or Guardian Date

Please list child's name:

_____

WAUCONDA PARK DISTRICT

PERMISSION TO DISPENSE MEDICATION WAIVER AND RELEASE OF ALL CLAIMS

The Wauconda Park District will not dispense medication to a minor child or any other participant until the Permission to Dispense Medications and Medication Information Form has been fully completed by a parent or guardian.

- Program Name:_____
- Participant's name: _____ Age: _____DOB: _____
- Parent's/Guardian's Name (s): _____
- Daytime Phone:_____ Other Phone:_____
    - Family Doctor's Name: _____
    - Phone: _____

MEDICATION INFORMATION:

- #1) Medication name:_____ Dose:_____ Time:_____
- Dispensing & Storage Instructions:_____
  _____
- Possible Side Effects:_____

- #2) Medication name:_____ Dose:_____ Time:_____
- Dispensing & Storage Instructions:_____
  _____
- Possible Side Effects:_____

Please list any possible side effect of medication and which medication they apply to:

_____

_____

Please list any additional information pertinent to your child's medication:

_____

_____

I, _____, the parent/guardian of _____ give permission to the Staff of the Wauconda Park District to administer the above medication to my child.

I understand it is my responsibility to give the medication directly to the program staff in the original dosage containers clearly labeled with the following information: Pharmacy's name, doctor's name, patient's name, type of medications, strength, and dosage instructions.

In all cases, the recommended dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I give my permission to the Wauconda Park District to secure from any licensed hospital physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered.

In consideration of the Wauconda Park District administering medication to my minor child, I do hereby fully and forever release and discharge the Wauconda Park District and its officers, agents, servants and employees from any and all claims I may have as a result of the Wauconda Park District Staff assisting in the administering of medication to by minor child.

Parent/Guardian Signature _____Date: _____

Automatic Credit Card Form

The Park District offers an automatic credit card payment option for Club and Kinderclub fees. Your credit card will be billed automatically on the 1st of each month for Club. When payment is completed you will receive a confirmation email.

Family Name_____

	Child's Full Name	Amount owed
1st Child	_____	$_____
2nd Child	_____	$_____
3rd Child	_____	$_____

Office use

Payer's Full Name_____ DOB_____
Parent responsible for paying

Total Payment Amount _____

Credit Card Information

Visa _____ Master Card _____ Discover _____

Credit Card Number_____-_____-_____-_____ CVC _____

Expiration Date _____

Cardholders Name **(Please Print)** _____

Address _____ Zip _____

Authorized Signature _____

Date _____

Note: If you filled out this form for Club 2016/2017 or camp 2017. A new form is required to be completed for Club 2017/2018 school year.

For Office Use Only:

Date Received: _____ Staff Initials: _____