

**WAUCONDA PARK DISTRICT
PARTICIPATION INFORMATION FORM
2019/2020 SCHOOL YEAR**

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

Home Phone _____ Parents Email: _____

School _____ Matthews Middle School _____ Robert Crown
_____ Wauconda Grade School _____ Wauconda Middle School

Grade (FALL 2019) _____

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. _____

<i>PARENTS WILL BE THE FIRST ONES CALLED IF THERE IS AN EMERGENCY</i>			
Emergency Contact Persons (If parent cannot be reached)			
	Name	/	Relationship
1.	_____	/	_____
			Phone # _____
2.	_____	/	_____
			Phone # _____
3.	_____	/	_____
			Phone # _____
4.	_____	/	_____
			Phone # _____
Persons authorized to pick up your child from club:			
	Name	/	Relationship
1.	_____	/	_____
			Phone # _____
2.	_____	/	_____
			Phone # _____
3.	_____	/	_____
			Phone # _____
4.	_____	/	_____
			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 cancellation/change policy outlined in this handbook.

Parent initials

2. I have fully read and understand the Wauconda Park District Club program behavior policy.

Parent initials

3. 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

4. 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 (Only complete this form if medication is to be dispensed during club)

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 my minor child.

Parent/Guardian Signature _____ Date: _____

**Automatic Credit Card Form
2019/2020 school year**

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.

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

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 2018/2019 or camp 2018. A new form is required to be completed for Club 2019/2020 school year.

For Office Use Only:

Date Received: _____ Staff Initials: _____