



# Recreation Services Health Care Form

For all Participants

The information on this form is not part of the participant or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to The City of Dublin Recreation Services personnel upon participant's arrival at the program. PLEASE provide complete information so that the program is aware of your child's needs.

Participant's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle

Home Address \_\_\_\_\_  
Street City State Zip

Shirt Size  Youth XS  Youth Small  Youth Medium  Youth Large  Adult Small  Adult Medium  Adult Large  Adult XL  
(4-6) (6-8) (10-12) (14-16)

Custodial Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
(if different from above) Street City State Zip

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City

Second Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
(if different from above) Street City State Zip

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City

If not available in an emergency, notify \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Parent /Guardian Authorizations: The health history and all other information provided on this form is correct and complete as far as I know, and the participant herein described has permission to engage in all camp and other recreation activities except for the restrictions I describe on page 2, if any. I agree to abide by any restrictions I have described on page 2 or any other restrictions placed upon the participant by the City if the City deems any additional restrictions necessary based on information I have provided in this form.

I hereby give permission to The City of Dublin Recreation Services to administer prescribed medications listed on page 2 of this form, to administer first aid, and to seek emergency medical treatment when the City deems it necessary. I give permission to the City to arrange necessary related emergency transportation for hospital care. The City will use reasonable efforts to notify me (or if I can't be reached, my emergency contact) in the event of an emergency, but I understand and agree the City may need to administer first aid or arrange for medical transportation before contacting me depending on the nature of the medical emergency. This completed form may be photocopied for trips away from the main recreation site. I agree to the release of any information maintained by the City to third party medical personnel regarding the participant if needed to render such first aid or arrange for the provision of emergency medical treatment, including emergency medical transportation.

Signature of Parent/Guardian \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

For religious or other reasons I chose not to sign this, and do not authorize treatment for the participant listed above.

Signature of Parent/Guardian \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**Signing this box does not affect a participant's access to the program.**

**\*This form is valid for all programs running from 1/1/09-1/9/10\***



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Last First Middle

### MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the duration of the entire camp/activity. Keep medications in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

<input type="checkbox"/> This person takes <b>NO MEDICATIONS</b> on a routine basis	OR	<input type="checkbox"/> This person <b>TAKES MEDICATIONS</b>
Med #1 _____ Dosage _____		What Time? _____
Reason for taking _____		
Med #2 _____ Dosage _____		What Time? _____
Reason for taking _____		
Attach additional pages for more medications.		
Please identify any medications taken during the school year that the participant does/may not take during the summer:		
_____		

### THIS CAMPER DOES NOT EAT

Red Meat  Pork  Dairy Products  Poultry  Seafood  Eggs  Wheat/Gluten  Other  
(Please Describe) \_\_\_\_\_

### SHOULD THIS CAMPER HAVE ANY RESTRICTIONS PLACED UPON HIS/HER ACTIVITY?

\_\_\_\_\_

**SPECIAL ACCOMMODATIONS** (please explain any special accommodations needed) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### ALLERGIES This person has NO KNOWN ALLERGIES OR This person HAS THE FOLLOWING ALLERGIES

Food  Medicine  The Environment (insect stings, hay fever, etc)  Other \_\_\_\_\_

Please describe specifically what the participant is allergic to and the reaction seen \_\_\_\_\_

**SUNSCREEN**  I give permission OR  I do NOT give permission  
to The City of Dublin, Recreation Services staff to apply sunscreen to this participant.

### SWIMMING ABILITY

Has this participant taken swim lessons?  Yes  No

Is this participant comfortable in water when he/she can't touch the bottom of the pool?  Yes  No

Should this camper have any restrictions at the pool \_\_\_\_\_

### GENERAL QUESTIONS (Explain "yes" answers below)

Has/does the participant:	Y	N		Y	N
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Had problems with joints?	<input type="checkbox"/>	<input type="checkbox"/>
3. Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance at the program?	<input type="checkbox"/>	<input type="checkbox"/>
4. Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (itching/rash/etc)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. If female, had an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
10. Passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
11. Been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
12. Had seizures?	<input type="checkbox"/>	<input type="checkbox"/>			
13. Had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
14. Had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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Last First Middle

**IMMUNIZATION HISTORY** Provide the month and year for each immunization. Copies of immunization forms from health-care providers or state or local government are acceptable—please attach records to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	<input type="checkbox"/> Negative <input type="checkbox"/> Positive
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**Which of the following has the participant had?**

- Measles  Chicken Pox  German Measles  Mumps  Hepatitis A  Hepatitis B  Hepatitis C

Please use this space to provide any additional information about the participant's behavioral, physical, or mental health about which The City of Dublin, Recreation Services should be aware. \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**For staff use:**

Staff review _____ Date _____ Time _____	Staff review _____ Date _____ Time _____
Staff review _____ Date _____ Time _____	Staff review _____ Date _____ Time _____
Staff review _____ Date _____ Time _____	Staff review _____ Date _____ Time _____
Staff review _____ Date _____ Time _____	Staff review _____ Date _____ Time _____
Staff review _____ Date _____ Time _____	Staff review _____ Date _____ Time _____
Staff review _____ Date _____ Time _____	Staff review _____ Date _____ Time _____
Staff review _____ Date _____ Time _____	Staff review _____ Date _____ Time _____
Staff review _____ Date _____ Time _____	Staff review _____ Date _____ Time _____

Meds received \_\_\_\_\_

Any needs identified \_\_\_\_\_



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Last First Middle

### Authorization for Child Pick-Up

I give permission to any person named on this document as a parent, guardian, second parent, second guardian, or emergency contact, or as otherwise set forth below as "Additional Authorized Persons," to pick up this participant from The City of Dublin Recreation Services camps/activities. I understand that I and any authorized persons must show appropriate identification (Pick-Up Pass, driver's license, photo ID) to remove this participant from The City of Dublin, Recreation Services camps/activities.

### **ADDITIONAL AUTHORIZED PERSONS**

- I do NOT authorize any additional people to pick up this participant from The City of Dublin Recreation Services camps/activities.
- I do authorize the following individuals to pick up this participant from The City of Dublin Recreation Services camps/activities (must be 18 years of age or older).

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_

### Camper Code of Conduct

In order for all recreation program participants to have a safe and enjoyable experience, all participants must demonstrate good behavior and respect for themselves as well as others. I have received, read, and understand the Camper Code of Conduct and agree to abide by all of the expectations stated in the Camper Code of Conduct.

Participant Name \_\_\_\_\_

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parents please have your CHILD sign here—to the best of their ability)

### Parent Handbook & Code of Conduct

I have read the Parent Handbook and understand the policies and procedures of this program. I agree to abide by the policies and procedures as outlined in the Parent Handbook, including the sign-in/out procedure, payment and refund policies, and late pick-up policies. I realize that failure to abide by these policies and procedures will result in the consequences outlined in the Parent Handbook up to and including cancellation of enrollment.

The City of Dublin Recreation Services has established guidelines for parent/guardian interaction when dropping off or picking up participants from programs and/or during camp trips or other activities. While parent/guardian involvement is important and encouraged, we have a responsibility to protect other participants in the program. Our goal is to establish clear guidelines for parents/guardians regarding interactions with children other than their own. I have received, read, and understand the Parent Code of Conduct and agree to abide by all of the expectations stated in the Parent Code of Conduct.

Parent/Guardian Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Parents/Guardians: All of the information provided on ALL FOUR PAGES of this form is accurate and current to the best of my knowledge, and I agree to abide by the guidelines and recommendations outlined on ALL FOUR PAGES of this form.** I understand that if I would like to make changes to this form I must present a driver's license or state issued identification card at the time the change is made. Only persons named as the custodial or secondary parent guardian are authorized to make changes to this form.

Signature of Parent/Guardian \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_