2017 Camp FUNshine Participant Form

Child's Information

Name: _____ _____ _____
Last First Age DOB

Full Address including ZIP: _____

Gender: M F

Week 1: June 19 - 23 ☐	Week 2: June 26 – 30 ☐	Week 3: July 3 – 7 ☐	Week 4: July 10 – 14 ☐
Week 5: July 17 - 21 ☐	Week 6: July 24 - 28 ☐	Week 7: July 31 – Aug 4 ☐	Xtreme Week: Aug 7 - 11 ☐

Contact Information

Mother/Guardian Information

Name: _____
Last First

Full Address including ZIP: _____
(Only if different from camper's)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Father/Guardian Information

Name: _____
Last First

Full Address including ZIP: _____
(Only if different from camper's)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Additional Information: Please list any information that may assist us in making your child's experience a positive one (For example: comforting tools, fears, etc.)

_____

_____

Allergies (State Allergy, Reaction and Treatment)

	Allergy	Reaction	Treatment
1.	_____	_____	_____
2.	_____	_____	_____

Physician's Information (Please attach or provide business card if available)

Name: _____ Phone: _____

Emergency Contact (other than parents/guardians)

1. Name: _____ _____
Last First Relationship to child

Full Address including ZIP: _____

Home Phone: _____ Cell Phone: _____

2. Name: _____ _____
Last First Relationship to child

Full Address including ZIP: _____

Home Phone: _____ Cell Phone: _____

Release Section

If parents of the camper are divorced, please list the name of who has legal custody of the child named on this application?_____

May the non-custodial parent pick up the child named on this application? ___ YES ____NO.

If yes, include required information in the release section. If no, legal documentation may be required.

The child named on this application will be released only to the people named as parents or emergency contacts on this application**. *Please be advised that identification will be required*.**

Camp FUNshine Policy and Procedure Agreement:

I_____ hereby acknowledge that I have read and agree to abide by the identified Camp FUNshine policies and procedures listed in the camp information package that was made available to me. I understand that a fee of **$1 per minute** will be charged for campers that are not registered for pre/post camp, arriving prior to 9AM or not picked up by 5PM. I understand that a fee of **$1 per minute** will be charged for campers that are registered for pre/post camp, arriving prior to 7:30AM or not picked up by 6PM.

Medical Care Authorization and Hold Harmless Agreement:

I _____also hereby acknowledge my receipt and understanding of the information disclosed on this registration form. I hereby grant permission to the Town of Matthews Staff to obtain medical care from any licensed physician, hospital, medical clinic or emergency medical service organization for the above named at such times as deemed necessary for physical health purposes. I hereby voluntarily release and discharge the Town of Matthews, the Matthews Parks and Recreation Department, its agents, contracted services, servants and employees from any and all claims for injury, illness, death, loss or damage, which my child may suffer as a result of his/her participation in the Town of Matthews activities.

PARENT/GUARDIAN SIGNATURE_____ DATE_____

MEDICATION AUTHORIZATION FOR CAMP "FUN"SHINE PARTICIPANTS

In order to help protect your child's health, your consent and written authorization from a licensed healthcare provider are required when it is necessary for your child to receive prescription and non-prescription medicines while a participant in Matthews Parks, Recreation and Cultural Resource Department's Camp FUNshine. Medications cannot be given to your child at camp until this authorization has been received. A separate form is required for each medicine. New authorization forms are required whenever the dosage or directions change or when a new medicine is prescribed. It is your responsibility to provide all medicines to be given during camp. Each medicine must be in an appropriately labeled original container from the pharmacy or healthcare provider's office. Most pharmacies will provide an extra container for use upon request. Administration of non-prescription medicine is discouraged.

Parent / Guardian's Permission: I give permission for my child to receive this medicine during camp operating hours. I understand that it is my responsibility to purchase and supply this medicine. On behalf of my child, I absolve the Town of Matthews, their agents and employees from any and all liability whatsoever that may result from my child taking this medicine while a participant in Matthews Parks, Recreation and Cultural Resource Department's Camp FUNshine.

_____ _____

Signature of parent or guardian Date

FOR HEALTH PROFESSIONAL USE ONLY: PLEASE WRITE LEGIBLY USING LAYMAN'S TERMS

Specific Directions

Medication prescribed:_____

Strength/Dosage:_____

Purpose of Medication:_____

Relationship to meals:_____

How often and what time:_____

Expected side effects or adverse reactions (specify):_____

_____

Other Instructions:_____

- Should this participant be allowed to self-administer this medication?_____
- Should this participant carry this medication with him/her at all times?_____
- Is this medication to be used for emergencies only?_____
- Other_____

It is necessary for this student to receive this medication during camp hours in order to maintain or improve health and to benefit from summer camp attendance. Please notify Matthews Parks and Recreation Staff if there are any problems.

_____

Signature of health provider Date Telephone# Fax#

_____

Please print health provider's name Practice name and address

For MPRCR Dept. Use

Date received / By_____