JCPRD Youth Camp Form 2020

JOHNSON COUNTY Park & Recreation District

TO BEGIN: "Save As" child's Last name, First name & Date of Birth (no slashes)

(ex. Kent, Clark 04152015)

Use the SUBMIT button below when form is complete.

Personal Data

Primary Program to Attend: Summer Escapades: Big Bull Creek (5-10 yo) **T-Shirt Size:** Youth Medium

Child's Name:_____ Age:_____ Birth Date:_____

Address:_____ Home Phone:_____

(Street) (City) (State/Zip)

Mother's Name:_____ Father's Name:_____

Main Phone # _____ Main Phone # _____

Work # & Ext._____ Work # & Ext._____

Emergency contact:

1._____ Phone #:_____ Relationship:_____

2._____ Phone #:_____ Relationship:_____

Doctor's Name:_____ Phone #:_____

Emergency Hospital Preference:_____

List Food/Substance Allergies:_____

Allergic to bees/insect stings? Yes ☐ No ☐ unknown ☐

List any required medications & specify purpose_____

Will drugs be administered during program hours? Specify. (Please note a medication form must be on file to administer.)

_____

List all individuals authorized to pick up your child.

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

(MUST HAVE PHOTO ID TO PICK UP CHILDREN)

What activities does he/she most enjoy?_____

What special interests would your youth like to explore?_____

Is there any special information that would be helpful in meeting the needs of your child? _____

_____

Specifically state any physical limitations:_____

Have there been any major changes at home that may affect your child? _____

_____

Please state goals for your youth's participation in this program:_____

Signature of Parent/Guardian*: _____ **Date:**_____

* I attest that the information here provided is complete to the best of my knowledge. Typing my name in this box serves as my signature, for legal purposes pertaining to JCPRD programs, and KDHE requirements.

JOHNSON COUNTY PARK & RECREATION DISTRICT

JOHNSON COUNTY PARK & RECREATION DISTRICT

JOHNSON COUNTY KANSAS

This JCPRD Youth Program Form is applicable for many JCPRD Youth Programs.
Not all programs participate in the following activities.
However, complete information will be necessary should the Youth register in programs requiring such information.

HIGH INTENSITY ACTIVITIES:

I give permission for my child to participate in the following High Intensity activities: (Check all that apply)

Swimming In Water Beyond Chest Depth ☐ Archery(8yrs and older ONLY) ☐ BB Gun Riflery(8yrs and older ONLY) ☐
Hiking ☐ Stream Hikes ☐ Pond Exploration ☐ Diving Board ☐ Fishing ☐ Low Ropes Challenge Course ☐
Swimming(Pools & Beaches) ☐ Canoeing & Kayaking*(8yrs and older ONLY) ☐ Pedal Boating* ☐ * All campers are required to wear a lifejacket for boating activities

Please explain any limitations or concerns for your child participating in these activities: _____

_____

List any fractures, dislocated joints, sprains, back or neck injuries, hospitalizations or surgeries your child has had in the last 3 years:

_____

AUTHORIZATIONS:

Transportation Authorization: I authorize transportation in district or leased vehicles to Pools & Beaches, Stream Hikes, Boating/Fishing Sites, and any Johnson County Park & Recreation District Parks and Facilities. (*In addition, guardians will need to sign weekly field trip permission forms*.) **AGREE*** ☐

Youth May Apply Health Products with Supervision: (Check All that apply)
Insect/Tick Repellent ☐ Sunscreen ☐

Parent and Participant Code of Conduct Acknowledgement: Please review the relevant program policy information for your program (available online) and review with your child. Program expectations and actions will be based on these policies and values.
I have read and understand the program mission, values, and policy statements and have reviewed the information with my child. **AGREE*** ☐

High Intensity Activities: In addition to those listed above, my child may participate in supervised and appropriately challenging activities, as deemed by program staff. **AGREE*** ☐

* I attest that the information here provided is complete to the best of my knowledge. Checking this box serves as my signature, for the legal purposes pertaining to JCPRD programs and KDHE requirements.

CCL. 358
Rev. 1/2014

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax (785) 296-0803
Website: www.kdheks.gov/kidsnet

HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

Complete one form for each child or youth attending the School Age Program.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)

First and Last Name of the Child's or Youth's Mother or Guardian

Mother/Guardian's Home Street Address	City	Zip Code	Home Phone #

Mother/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone #

First and Last Name of the Child's or Youth's Father or Guardian

Father/Guardian's Home Street Address	City	Zip Code	Home Phone

Father/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone #

Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)

Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.	City	Zip Code	Phone Number (during program hours):
1.			
2.			
3.			

First and Last Name of Physician & Street Address	City	Zip Code	Phone Number

Name of Hospital Preference in case of emergency.

Yes	No	N/A	Complete the following information about medications for this child or youth.
-			Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
-			If yes above, is there signed permission on file?

Circle any of the following conditions or difficulties that affect this child or youth.			
Allergies ☐	Frequent sore throats/ colds ☐	Ear Infections or Aches ☐	Heart or Lung Conditions ☐
Skin Problems ☐	Asthma ☐	Headaches ☐	Diabetes ☐
Vision ☐	Speech/Communication ☐	Hearing ☐	Emotion/Behavior ☐
Other: Please describe.			

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.

Complete the following information about this child's or youth's immunization status.

Yes	No	
-		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
-		If yes, are this child's or youth's immunizations current? Please note the instruction below regarding immunization records...
X	X	If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Influ. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed

If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form*	Date Signed

CCL 010
Rev. 8/2013

Kansas Department of Health and Environment
Bureau of Family Health
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Program: (785) 296 -1270 Fax: (785) 296 -0803
Foster Care Program: (785) 296 -1270 Fax: (785) 296 -7025
Website: www.kdheks.gov/kidsnet

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license.	**License #**
For Office use Only	For Office Use Only

I hereby authorize Johnson County Park & Recreation District (Name of individual/staff member) and/or Program Administration & Staff (Name of individual/staff member) who is (are) representative(s) of the above named facility to give consent for any and all necessary emergency medical care for my child or youth _____ (First and Last Name of Child or Youth) while said child or youth is in said facility's custody between the dates of _____ (MM/DD/YYYY) and Until Terminated (MM/DD/YYYY).

Signature of Parent or Guardian*	**Date Signed**

Witness to Parent's or Guardian's signature if required by the local hospital o	**Date Signed**

Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

State of Kansas
County of _____

Signed or attested before me on _____ (MM/DD/YYYY) by _____ (Name of Person).

(Seal, if any.)

NO NOTARY REQUIRED

_____
Signature of notarial officer

_____
Title (and Rank)

My appointment expires: _____

List any known allergies or other information about the medical status of this child or youth pertinent in case of emergency:

_____

_____

Is child covered by health insurance? ☐ **Yes** ☐ **No**

If yes, complete the following:

Health Insurance Policy Name _____ Policy Number _____

Medical Assistance Program _____ Card Number _____

Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation: _____

THE MEDICAL RECORD/ASSESSMENT FORM (OR HEALTH STATUS HISTORY FORM FOR SCHOOL AGE PROGRAMS) AND THE AUTHORIZATION FOR EMERGENCY MEDICAL CARE MUST BE TAKEN TO THE EMERGENCY ROOM. BOTH FORMS MUST ALSO BE IN A VEHICLE WHEN THE CHILD OR YOUTH IS TRANSPORTED BY THE FACILITY.

Please complete all required fields and provide additional information where appropriate.

“Save As” the child's Last name, First name & Date of Birth (no slashes)

(ex. Kent, Clark 04152015)

Use the SUBMIT button below when form is complete.

Submit Via Email

Forms will be submitted via Email to: PRK-YouthForms@jocogov.org

NOTE: Please retain a copy for your records.

If forms are not submitted 14 Days prior to program’s start date, please bring a completed paper copy to the first day of program.

Privacy Disclosure: All contents of participant’s release of liability, waiver, and health statement forms are confidential documents and will not be duplicated, distributed, discussed, and/or viewed by anyone other than the program facilitator, program staff, and emergency medical personnel unless otherwise required by law.