JOHNSON COUNTY
Park & Recreation
District

Please print or type and complete one Personal Data Form for each child enrolled

JOHNSON COUNTY PARK AND RECREATION DISTRICT
2019 Summer Camp PERSONAL DATA FORM

School/Camp Name: ______________________________

Child's Name:____________________________ Age:____________________________

Grade (2019-20)__________________________ Birth Date:________________________

Address:____
(Street) (City) (State/Zip)

Parent Name:____________________________ Home#: ____________________
Relationship to Child:____________________ Work # & Ext. ________________
E-Mail__________________________________ Cell # ______________________

Parent Name:____________________________ Home # _____________________
Relationship to Child:____________________ Work # & Ext.________________
E-Mail _________________________________ Cell # ______________________
Emergency contact: ______________________ Phone #:_____________________
Relationship:______________________
____________________________ Phone _____________________
Relationship:______________________

Doctor's Name:________________________________ Phone #:________________

Emergency Hospital Preference:____

List Food/Substance Allergies:____

Is child taking Prescription drugs, specify?__________________________________

Will drugs be administered during care hours, specify?_________________________

The JCPRD program is authorized to release my child to the following individuals without advance written or verbal permission:

Name:______________________ Relationship:____________ Phone #:______________
Name:______________________ Relationship:____________ Phone #:______________
Name:______________________ Relationship:____________ Phone #:______________

(MUST HAVE PHOTO ID TO PICK UP CHILDREN)

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

Specifically state any physical limitations:___________________________________
____

Please state goals for your child's participation in this program:__________________
____

Will your child be leaving the camp for lessons, clubs, etc.? (Please state days/times)
____
____

List special programs, skills or activities you would like to have introduced in the program______
____

X Signature of Parent/Guardian:________________________________ Date:_____________

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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. **1.**	**City**	**Zip Code**	**Phone Number (during program hours):**
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?
		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**

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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 #**

I hereby authorize ___________JCPRD Staff_______________________________ (Name of individual/staff member) and/or

____ (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 ___________________________ and ___until care is terminated_.
MM/DD/YYYY MM/DD/YYYY

Signature of Parent or Guardian	**Date Signed**

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	**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 _____________________ by____.
MM/DD/YYYY Name of Person

(Seal, if any.)

____
Signature of notarial officer

Notary Not Required

____
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.