Participant Information Packet

Summer 2020

NAME OF CHILD:_____AGE_____BIRTHDATE_____SEX: M F

ADDRESS:_____
Street City State Zip Code

PHONE:_____ PHONE:_____

EMAIL:_____ EMAIL:_____

SCHOOL ATTENDING_____GRADE(Fall '20)_____

PARENTS/GUARDIANS WITH WHOM THE CHILD RESIDES:

NAME:	NAME:
RELATIONSHIP:	RELATIONSHIP:
CELL PHONE	CELL PHONE
EMPLOYER:	EMPLOYER:
WORK HOURS:	WORK HOURS:
BUSINESS PHONE:	BUSINESS PHONE:
BUSINESS ADDRESS:	BUSINESS ADDRESS:
CITY/STATE/ZIP:	CITY/STATE/ZIP:

PERSONS TO CONTACT IF PARENTS ARE UNAVAILABLE

BY LISTING THESE PEOPLE YOU ARE ALSO AUTHORIZING THAT THEY MAY PICK YOU CHILD UP:

NAME:	NAME:
RELATIONSHIP:	RELATIONSHIP:
DAY PHONE:	DAY PHONE:
EVENING PHONE:	EVENING PHONE:
ADDRESS:	ADDRESS:

Additional persons may be listed on the back of this form.

Signature of Parent/Guardian Signature of Parent/Guardian

Date: Date:

Are there any Custody Restraints/Person(s) who <u>MAY NOT</u> pick up your child? No Yes (explain below)

_____

_____

EMERGENCY MEDICAL CONSENT FORM AND HEALTH CARE INFORMATION

Child's Name:_____ **Birthdate**:_____

Child's Doctor:_____ **Phone:** _____ **Address**:_____

Child's Dentist:_____ **Phone:**_____ **Address**:_____

Iowa City Hospital Preferred:_____

Date of Last Tetanus:_____ **Are all immunizations current?: Yes No**

Parent Signature that all immunizations are up to date: _____

Allergies: (please include drug, food, or pest)_____

_____

Present Medication:_____

_____

A medication release form must be completed for all medications distributed at SPARK, including over the counter items.

Insurance Company:_____ **Policy Holder's I.D.:**_____

Please list significant illnesses and surgeries child has had (give age at time).

_____

Attach additional sheets as needed:

Does your child have any physical condition or disability, which our staff should be aware of? Would this restrict his/her activity? Please explain condition and accommodation required:

Is this child subject to any condition, which limits classroom or physical activities?

Is this child subject to any mental or physical condition for which he/she should remain under periodic medical observation? For behavior conditions, please explain approach used at home/school to correct:

Other information you would like to share:

THIS CONSENT GIVES PERMISSION FOR MEDICAL CARE IN PARENTAL/GUARDIAN ABSENCE AND MUST BE PRESENTED UPON ADMISSION FOR TREATMENT. EVERY EFFORT WILL BE MADE TO NOTIFY THE PARENT/GUARDIAN IMMEDIATELY IN CARE OF EMERGENCY, ILLNESS, OR INJURY. IN THE EVENT THAT THE PARENT CANNOT BE CONTACTED OR ARRIVE AT SPARK IN AMPLE TIME, THE CHILD WILL BE TRANSPORTED BY AMBULANCE IN AN EMERGENCY SITUATION.

IN THE EVENT THAT MY CHILD REQUIRES MEDICAL OR SURGICAL CARE WHILE I AM OUT OF THE CITY OR UNABLE TO BE REACHED, I HEARBY GIVE CONSENT TO MEDICAL OR SURGICAL TREATMENT TO THE ABOVE HOSPITAL AND/OR DOCTOR. I AGREE TO PAY ALL COSTS AND FEES CONTINGENT ON ANY EMERGENCY CARE AND/OR TREATMENT FOR MY CHILD AS SECURED OR AUTHORIZED UNDER THIS CONSENT. THIS CONSENT WILL BE IN EFFECT FROM May 15, 2020 – June 1, 2021.

_____

SIGNATURE OF PARENT/GUARDIAN **SIGNATURE OF PARENT/GUARDIAN**

DATE:_____ **DATE**:_____

TRAVEL AUTHORIZATION

I give permission for my child, _____, to leave Coralville Recreation Department for program field trips by foot, department van, or by bus with SPARK. I understand that I will be notified by schedule handout and/or posted message before each trip.

_____ _____
Parent/Guardian Initial Date

LATE FEES

I understand that an early fee of $1 per every 1 minute early will be assessed before my child's scheduled drop off time and a late fee of $1 per every 1 minute late will be assessed after my child's scheduled departure time. Early and late fees must be paid within one week of the date.

_____ _____
Parent/Guardian Initial Date

IMMUNIZATION RECORD STATUS

My child's immunization records are current as required by the State of Iowa Public Health for my child to attend school.

_____ _____
Parent/Guardian Initial Date

PHOTOS

Registrants and participants permit the taking of photos and videotapes of themselves and their children during City of Coralville sponsored activities for publication and use, as the department deems necessary.

WAIVER FOR PARTICIPANT BY PARENT

In consideration of accepting my child's entry into the Coralville Parks and Recreation Department's SPARK programs, I hereby, for myself, my child, my heirs, executors and administrators, waive and release any and all rights and claims for damages I, or my child may have against the Coralville Parks and Recreation Commission, City Council, and its successors and assigns, its employees, agents, officers and directors for any and all injuries suffered by myself or my child at an activity sponsored by these groups.

The Coralville Parks and Recreation Department will immediately involve the authorities if any child should run away from program. I further understand the risks inherent to the activity for which my child is entering.

I understand that the rules of SPARK are designed for the well being and safety of the children participating, and failure to comply with these rules may result in suspension from program activities.

Signature:_____ Date:_____

CORALVILLE

CONSENT FOR GIVING OF MEDICATIONS

COMPLETE THIS FORM ONLY IF YOUR CHILD WILL BE TAKING MEDICATION DURING PROGRAM HOURS

I (Parent/Guardian) _____, give consent to the City of Coralville to hold my child's medication for while at a SPARK program.

The medication must be in the original container and contain no more than a 30-day supply. I understand that the Coralville Recreation Department will hold the medication before and after the child is to take it and will observe he/she taking the medication. It is the responsibility of the parent to provide the tool for which the proper dosage is given. If a pill is to be taken as a half, the pills must be cut in half by the parent.

The following medication will be received from (Parent/Guardian): _____

_____ **For use by (participant):** _____

Medication	Amount	Time to be given	Date

Date: _____ **Signature:** _____

THE UNDERSIGNED PARENT(S) AND/OR GUARDIAN(S) HEREBY ACKNOWLEDGE THAT THESE SERVICES ARE SOLELY FOR THE CONVENIENCE OF THE RECIPIENT, THAT SUCH SERVICE WILL BE PROVIDED BY A PERSON WHO IS NOT A HEALTH PROFESSIONAL; NEVERTHELESS, THE UNDERSIGNED AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS THE CITY OF CORALVILLE, ITS OFFICERS, AGENTS, EMPLOYEES AND RECREATION DIVISION STAFF FROM ANY AND ALL CLAIMS, DAMAGES, COSTS, CHARGES, EXPENSES AND SUITS ARISING OUT OF, OR RESULTING FROM, THE GIVING, OR FAILURE TO GIVE MEDICATION AS PROVIDED ABOVE.

Date: _____ **Signature (Parent/Guardian):** _____