1899 West Winchester Road, Libertyville, Illinois 60048 |Telephone 847-367-6640 | email forestpreserves@LCFPD.org

LAKE COUNTY FOREST PRESERVES
www.LCFPD.org

Preservation, Restoration, Education and Recreation

Emergency Contact & Health Form

THIS FORM AND THE WAIVER AND RELEASE FORM ARE DUE ON DAY OF PROGRAM. One form per child serves all registrations. However, an original signature is required on health forms and waivers.

NAME OF PARTICIPANT | Birthdate (Month / Day / Year) | Entering Grade

Address | City | State | ZIP

PROGRAM NAME & DATE(S):	PRESERVE(S):

Emergency Contact Information

List phone number where emergency contacts can be reached **during the program hours** (usually daytime phone and cell).

MOTHER: | Daytime Phone: | Cell:

FATHER: | Daytime Phone: | Cell:

ALTERNATE 1 EMERGENCY CONTACT: | Relationship: | Phone:

ALTERNATE 2 EMERGENCY CONTACT: | Relationship: | Phone:

MAY WE CONTACT YOU VIA EMAIL? Y / N | Email address:

Child Pick-Up

Anyone picking up your child will need to present a photo ID (i.e. drivers license) for release of your child. We will not release your child unless proper identification is given. Please list persons (including yourself) authorized to pick up your child.

Print clearly please:

_____

_____

_____

NAME OF PARTICIPANT | Birthdate (Month / Day / Year) | Entering Grade

Medical Information

ALLERGIES & DIETARY RESTRICTIONS. Please list, describe reaction and management of the reaction as applicable.

MEDICATIONS. Please list all medications (including over-the-counter or nonprescription) taken regularly, or if they are on a drug holiday. Children are expected to bring whatever medical supplies or medications they will need and turn it in to staff, along with written instructions. Staff will be happy to remind them to take medication if we are notified in writing about their schedule.

MEDICATION: Dosage: Specific time taken:

Reason for taking:

MEDICATION: Dosage: Specific time taken:

Reason for taking:

HEALTH INSURANCE / PHYSICIAN

Insurance Company | Policy/Group Number | Participant ID Number

Physician's name | Office Phone Number

IMMUNIZATIONS. Y / N Are the child's immunizations current?

/ / Date of last Tetanus shot

PAST MEDICAL TREATMENT. Please list any major medical treatment, type and date:

NOTIFICATION. Y / N Do you want to be notified immediately for minor injuries (e.g., scrape, non-allergic bee sting, bloody nose, sliver) that do not limit participation in the program?

SPECIAL NEEDS. *Are there any physical, mental, psychological or behavioral conditions requiring medication, treatment, or special restrictions or considerations of which we should be aware to ensure your child's fullest enjoyment of the program? Please describe, including any special accommodations necessary. Please note that it is your responsibility to supply any necessary medical equipment which relates to a specific medical condition. Are there any activities from which the child should be exempted for health reasons?*

Permission to Secure Treatment

In the event of any emergency, I authorize the Lake County Forest Preserve District to secure from any licensed hospital, physician and/or medical personnel any treatment deemed necessary for me or my minor child/ward's immediate care and agree that I will be responsible for payment of any and all medical services rendered. I understand that this authorization includes transporting my child by ambulance if necessary to the nearest medical treatment facility or hospital if I am unable to be reached first.

SIGNATURE OF PARENT OR GUARDIAN | DATE

PRINTED NAME