
NAME OF PARTICIPANT

Persons Authorized for Child Pick-Up (in addition to emergency contacts listed on previous page)

Camp staff will not release your child unless proper photo identification is shown daily by the persons listed. Print clearly and remember to include yourself if you plan to pick-up your child from camp.

MEDICAL INFORMATION and SPECIAL CONSIDERATIONS

Check any that apply to your child. With awareness of your child's needs, staff may be able to modify activities and techniques for inclusiveness prior to the start of the camp.

- No specific medical or behavioral condition
- Food allergies – please specify _____
- Non-food allergies –please specify _____
- Any physical, emotional or behavioral conditions, including cognitive, LD, ADD, ADHD, or autism requiring medication, treatment, special restrictions or considerations while at camp– Please specify _____

◆ List triggers, signs or symptoms for these conditions:

◆ What techniques do you recommend in managing your child's behavior:

List activities from which the camper should be exempted for health reasons or require special accommodations:

Please note that it is your responsibility to supply any necessary medical equipment that relates to a specific medical condition.

Medications: List below all medications, including EpiPen, asthma inhaler, over-the-counter or nonprescription drugs, taken regularly. *If your child needs to take medication or you expect camp staff to dispense medication to your child during camp hours, you must also complete the separate Medication Dispensing Information, Waiver and Release form.*

MEDICATION	DOSAGE	SPECIFIC TIME TAKEN	REASON FOR TAKING
• MEDICATION	DOSAGE	SPECIFIC TIME TAKEN	REASON FOR TAKING

Check box if your child is taken off a particular medication in the summer.

NAME OF PARTICIPANT

HEALTH INSURANCE / PHYSICIAN

Insurance Company

Policy/Group Number

Participant ID Number

Physician's name

Office Phone Number _____

Date of last Tetanus shot (mm/dd/yyyy) _____ Immunizations: Are the child's immunizations current? Yes No

Past Medical Treatment: Please list any major medical treatment within the last year:

Notification: When you want to be notified for *minor* injuries (e.g. scrape, non-allergic bee sting, bloody nose, sliver) that do not limit participation? immediately at camper pick up

Permission to Secure Treatment

All camp staff are certified in First Aid, CPR, AED, EpiPen and asthma inhaler assistance. They will take whatever emergency medical measures are deemed necessary for the protection and safety of the camper within their training.

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 if I am unable to be reached first.

SIGNATURE OF PARENT OR GUARDIAN

DATE

PRINTED NAME

Day Camp Waiver & Release



NAME OF PARTICIPANT

Birthdate (Month / Day / Year) Entering Grade

Please read this form carefully and be aware in registering your minor child/ward for participation in the program or programs listed above you will be waiving and releasing all claims for injuries you or your minor child/ward might sustain arising from that program.

Important Information

The Lake County Forest Preserve District is committed to conducting its programs and activities in the safest manner possible and holds the safety of participants in the highest possible regard. Participants and parents registering their children in programs and activities must recognize, however, that there is an inherent risk of injury when choosing to participate. The Lake County Forest Preserve District strives to reduce such risks and insists that all participants follow safety rules and instructions which have been designed to protect the participant's safety.

Please recognize that the Lake County Forest Preserve District does not carry medical accident insurance for injuries sustained in its programs and activities. The cost of such medical expense would make program fees prohibitive. Therefore, each person registering themselves or a family member for a program or activity should review their own health insurance policy for coverage. It must be noted that the absence of health insurance coverage does not make the Lake County Forest Preserve District automatically responsible for the payment of medical expenses. Your cooperation is greatly appreciated.

Release of Liability & Permission to Secure Treatment

I recognize and acknowledge that there are certain risks of physical injury to participants in the above program(s) and I agree to assume the full risk of any injuries, damages or loss regardless of severity which I or my minor child/ward may sustain as a result of participating in any and all activities connected with or associated with such program(s).

I agree to waive and relinquish all claims I or my minor child/ward may have against the Lake County Forest Preserve District and its officers, agents, volunteers and employees as a result of participation in the program.

I do hereby fully release and discharge the Lake County Forest Preserve District and its officers, agents, volunteers and employees from any and all claims from injury, damage or loss with the activities of the program(s).

I further agree to indemnify and hold harmless and defend the Lake County Forest Preserve District and its officers, agents, servants and employees from any and all claims resulting from injuries, damages, and losses sustained by me or my minor child arising out of, connected with, or in any way associated with the activities of the program(s).

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.

Photography Release

I give permission for my child's picture to be used in advertisements for the Lake County Forest Preserves.

I have read and fully understand the above Release of Liability and Permission to Secure Treatment and Photography Release.

SIGNATURE OF OR PARENT / GUARDIAN)

DATE

PRINTED NAME