WAYLAND RECREATION DEPARTMENT | SKI PROGRAM 2018

YOUR CHILD CANNOT ATTEND WITHOUT SUBMITTING ALL 4 OF THESE REQUIREMENTS

☐ THIS HEALTH HISTORY FORM ☐ IMMNIZATION RECORD ☐ PHYSICAL EXAM ☐ PHOTO OF CHILD

Attach or send a current PHOTO of your child; will be kept in your child's file as part of our safety protocols.
You can email it from your mobile device!

CHILD'S FULL NAME:____ Gender: Male ☐ Female ☐

Address:____ City:____________________ Zip Code:__________

Date of Birth:_____________________ Age:________ How did you hear about us?__________________________

Grade for 2017-2018 school year: _______________________School: ___________________________________

Eye Color___________Hair Color__________Weight____________Height_____________ Sex__________

HEALTH HISTORY

ALLERGIES ☐ No known allergies. ☐Food ☐Medication ☐Seasonal/Environmental (insect stings, hay fever, etc.)
☐ Other (Please describe the allergy/reactions.) ____

PLEASE provide a snack and water every day!!!!

MEDICATIONS ☐ No medications ☐Prescribed an Epi-Pen* ☐Prescribed Inhaler* ☐ Other (Please describe)

____

Will medication need to be administered at the ski program? **YES** ☐ **NO** ☐ ***If yes, Complete Med Form

DIET/ NUTRITION

☐ Child eats a regular diet ☐ Vegan/Vegetarian ☐ Lactose intolerant ☐Gluten intolerant. ☐Other, please explain:

____

RESTRICTIONS

☐ I have reviewed the program and activities and feel my child can participate without restrictions.

☐ I have reviewed the program and activities and feel my child can participate with these restrictions or adaptations

____

PLEASE PROVIDE any additional information about the child's health that you think is important or that may affect the ability to fully participate in the program. Attach additional information if needed.

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HEALTH CARE PROVIDER

Name of child's Primary Physician/ Health Care Provider or Health Maintenance Organization:_______________________

Address:____Phone: ______________________________

Name of dentist(s):_____________________________________Phone:_______________________________

Medical Insurance Company ________________________________Policy#:_____________________________

FIRST AID & EMERGENCIES | INJURIES & ILLNESS

I authorize certified staff to give Basic First Aid/CPR/AED to my child if needed. In the event of an emergency, I hereby authorize my child be transported to the nearest medical facility as deemed appropriate by responding medical personnel and secure necessary medical treatment. In the event that I cannot be reached, I authorize the physician attending to my child to secure and administer treatment as necessary. I understand that the staff will make every effort to notify me and/or my emergency contacts of the emergency immediately. I authorize the staff to contact and to release my child to the emergency contacts that I designate on this form. Minor injuries will be reported to parents at the end of the day; minor illness will be reported to parents at the onset.

RELEASE OF CHILDREN | PICK-UP PROCEDURES

IMPORTANT: For safety, our staff can only release a child to a person who is authorized by the parent in writing and who has presented proper identification. Children are released once staff has checked a **photo ID** -- even IDs of the parent/guardians!

PARENT/GUARDIAN SIGNATURE____DATE_________

CHILD'S FULL NAME:____

LATE PICK-UP POLICY

A late pick-up fee of $1 per minute will be charged if the pick-up time exceeds five minutes after the registered dismissal time; After a 60 minute period of time and no contact has been made by a parent the Police Department and/or Department of Children and Families may be notified.

PARENT | GUARDIAN 1: APPROVED TO DISMISS

Parent Name:____Relationship:______________________

Address:____ City:____________________ Zip Code:__________

Home Phone:____________________Work Phone:____________________Cell Phone:____________________

Employer:______________________________Email:____

PARENT | GUARDIAN 2: APPROVED TO DISMISS

Parent Name:____Relationship:______________________

Address:____ City:____________________ Zip Code:__________

Home Phone:____________________Work Phone:____________________Cell Phone:____________________

Employer:______________________________Email:____

EMERGENCY CONTACTS/APPROVED TO DISMISS

Name:_________________________________Relationship:______________ Phone:_________________________

Name:_________________________________ Relationship:______________ Phone:_________________________

Is there someone, who you would like us to be aware of, who **cannot** pickup your child? ______________________

____

*Please note: If person listed above is also a legal parent/guardian, a court order is required to refuse release.

ADDITIONAL EMERGENCY CONTACT INFORMATION:

Travel date(s) location(s) and telephone number(s) of the parent/guardian if will be traveling while the child is attending the program:

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PERMISSIONS & AUTHORIZATIONS

Mark NO ☐ if you want to deny permission.   If you do not mark YES or NO, it is presumed you are granting permission.

The Recreation Department may make, have, use, publish and reproduce photographs and/or video of my child for its record, public relations purposes, children's recognition, slide shows and/or other projects related to the wholesome promotion of the program.

☐ **YES**   ☐ **NO PHOTOS or VIDEOS**

I realize that participation in the aforesaid program involves some risk of personal injury; therefore, I hereby release and covenant to hold harmless the Town of Wayland, its agents, contractors and employees of and from any and all actions, claims and damages for personal injuries and disabilities that I or my child may have sustained and may have incurred as a result of participation in your program.

PARENT/GUARDIAN SIGNATURE____DATE__________