

**TOWN OF BLOOMING GROVE RECREATION
REGISTRATION FORM – CHILDREN**

NAME OF PROGRAM _____ TODAY'S DATE _____

1. PARTICIPANT'S NAME _____ AGE _____ BIRTHDAY ____/____/____

2. PARTICIPANT'S NAME _____ AGE _____ BIRTHDAY ____/____/____

3. PARTICIPANT'S NAME _____ AGE _____ BIRTHDAY ____/____/____

LEGAL PARENT'S/GUARDIAN'S NAME _____

ADDRESS _____

HOME PHONE # _____ CELL # _____

EMAIL ADDRESS: _____ WORK# _____

HEALTH/MEDICAL RESTRICTIONS _____

LOCAL EMERGENCY NAME AND PHONE # (NOT YOUR OWN) _____

GRADE/SCHOOL _____

In consideration of the Town granting and continuing permission for use of its facilities, programs, and personnel, I hereby authorize my child, whose name appears above, to participate in the Town of Blooming Grove Recreation program; to travel to and from facilities and events conducted by the department. I hereby release the Town of Blooming Grove and its employees from any liability, claims, damage, or expense sustained by my child in connection with such participation.

In case of injury while at the program, I give permission for my child to be taken to a hospital for treatment – to include evaluation for injuries, X-ray, and any needed care. I understand the group leader will try to contact me in case injury occurs.

I have explained to my child that he/she is to obey the Town of Blooming Grove Staff and to follow rules and regulations set forth by them.

As with all Town of Blooming Grove Recreation Programs, credit is given only if a program is cancelled. Transfer of monies from one program to another is not permitted. There will be no credit or refunds if an instructor leaves during the session and is replaced within two weeks.

Legal Parent/Guardian Signature

FOR OFFICE USE ONLY:

Payment Amount: \$ _____

Cash _____ Check # _____ Money Order# _____ Receipt# _____

**TOWN OF BLOOMING GROVE SUMMER CAMP PROGRAM 2019
AUTHORIZED PICK-UP LIST**

Camper Name: **Last** _____ **First** _____

Please list ALL persons who are authorized to pick your child up from camp.

1. _____ Phone # _____

2. _____ Phone # _____

3. _____ Phone # _____

4. _____ Phone # _____

5. _____ Phone # _____

6. _____ Phone # _____

7. _____ Phone # _____

8. _____ Phone # _____

Print Parent/Guardian Full Name

X _____
Parent/Guardian Signature

Blooming Grove Rec use only-----

_____ **Immunization Records rec'd**

_____ **Permission slips rec'd**

Special needs, medical, allergies, etc:

TOWN OF BLOOMING GROVE SUMMER CAMP PROGRAM 2019
MEDICAL HISTORY FORM

Camper's Name _____ Phone (H) _____ (C) _____

Address _____
(Including name of road/street, P.O. Box #)

Age _____ Date of Birth _____

Are you a resident of the Town of Blooming Grove? Yes _____ No _____

(A resident pays property taxes to, and votes in Blooming Grove)

Emergency Name and Phone (not your own) 1. _____
Please List two Names 2. _____

MEDICAL HISTORY

Has your child been under any medical care within the past year? Yes _____ No _____

Reason: _____

Is the child on any medication now? Yes _____ No _____

What? _____

(Written Doctor approval is needed before the Camp Medical Personnel can administer medication)

Is your child allergic to Penicillin, or any other drug? Yes _____ No _____

What? _____

Does your child have other allergies? (i.e. bee stings, nuts, grass, etc.) Yes _____ No _____

What? _____

Is your child subject to:

- | | | |
|--|--|--|
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Wetting |
| <input type="checkbox"/> Stomach Upsets | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Abdominal Pains | <input type="checkbox"/> Cramps (Where? _____) | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Serious Ivy/Oak/Sumac Poisoning | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Other _____ | | |

Does your child have: Lung Problems Kidney Problems Heart Problems
 Hernia Epilepsy Other _____

Does your child have emotional, or mental limitations? Yes _____ No _____

If yes, please elaborate: _____

Has your child been exposed to any contagious disease in the past 3 weeks? Yes _____ No _____

If yes, what and when? _____

Should your child be restricted from any activity? Yes _____ No _____ If so, what? _____

IMMUNIZATION RECORD (Please indicate dates) Camper must have tetanus shot.

Optional~ Copy of medical records OR this section filled out and signed by a Physician

Tetanus - _____	Rubella - _____
Mumps - _____	Poliomyelitis - _____
Diphtheria - _____	Measles - _____
Chicken Pox - _____	Pneumonia - _____
Other - _____	Other - _____

Doctor's Name Printed _____ Office Address _____

Doctor's Signature _____ Office Phone # _____