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) _____

WEEKS ATTENDING(1-5): _____

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 #**_____

_____ X_____

Print Parent/Guardian Full Name **Parent/Guardian Signature**

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:

___ Fainting Spells	**___ Hay Fever**	**___ Headaches**
___ Eczema	**___ Tonsillitis**	**___ Wetting**
___ Stomach Upsets	**___ Diabetes**	**___ Asthma**
___ Abdominal Pains	**___ Cramps (Where?_____)**	**___ Convulsions**
___ Frequent Sore Throats	**___ Ear Infections**	**___ Sinus Trouble**
___ Serious Ivy/Oak/Sumac Poisoning	**___ Bronchitis**	**___ Constipation**
___ 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 (<u>Please indicate dates</u>) Camper <u>must have tetanus shot.</u>

*****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 # _____**