State Required Forms- Day Camps

Office Use only: First Date of Camp: ___/____/____

Campers Information		
Last Name:	First Name:	
Birth Date:	Age:	Gender: ☐ Male / Female ☐
Lives With: Mother ☐ Father ☐ Both Parents ☐ Grandparent ☐ Other: _____		

Parent / Guardian 1 Information	Parent / Guardian 2 Information
Name:	Name:
Physical Address:	Physical Address:
City: State: Zip:	City: State: Zip:
Employer:	Employer:
Location: Work#	Location: Work#
Cell # Home #	Cell # Home #
Email:	Email:

Special Instructions For Reaching Parents: _____

_____

Authorized Persons to Pick Up Child (*any changes or additions must be made in writing*):

Name	Home Phone	Work Phone	Cell Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Emergency Contact (*other than parents, who will also be authorized to pick-up child*):

Name	Address	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Contact Information

Doctor: _____ Address: _____ Phone: _____

Dentist: _____ Address: _____ Phone: _____

Hospital: _____ Address: _____ Phone: _____

Insurance Company: _____ Policy #: _____

Does your child have any chronic illnesses, allergies, medication needs, special diets, as well as any emotional or behavioral concerns: Please circle: Yes ☐ No ☐ If Yes, please explain: _____

_____

Are there any activities your child is unable to participate in due to physical, social or religious reasons? Please circle: Yes / No If yes, please explain: _____

_____

Parent's Signature: _____ Date: _____

ADDITIONAL WAIVERS

Camper's Name: _____ Camper's Grade in Fall: _____

___ Parent Handbook: I have received the Day Camps Parent Handbook/Registration Guide and agree to familiarize myself to understand all policies, procedures and activities relating to my child participation.

___ Participant Waiver: I understand that the registered activities and services may have an element of hazard or inherent danger and I take full responsibility for my and /or children's actions and physical condition. I agree to indemnify and hold W.E.C.M.R.D and its Directors, Officers, agents and employees from liability, loss, cost or expenses (including attorney fees, medical and ambulance costs) that I may incur in registered activities.

___ Activity Participation: My child has permission to participate in walking and/or traveling field trips and program activities sponsored by W.E.C.M.R.D. All walking field trips will be posted at your camp location the day of the trip.

___ Transportation Permission: My child has my permission to be transported by W.E.C.M.R.D, Eagle County School District staff and personnel for scheduled activities.

___ Emergency Medical Authorization: I hereby give my permission to the W.E.C.M.R.D to call a doctor or transport for medical or surgical care for my child listed above should an emergency arise. It is understood that a conscientious effort will be made to locate me or my spouse before any action will be taken; but if it is not possible to locate us, this expense will be accepted by us.

___ Sun Screen Waiver: I give employees of W.E.C.M.R.D program permission to apply sunscreen to my child on an as-needed basis, as prescribed by the directions on the bottle. Our camps use Rocky Mountain Sunscreen.

___ Movies: I give permission for my child to view movies rated (G and PG) while in Day Camps. (normally used for either educational purposes, lasting inclement weather or special events).

___ Photo Release: My child and I give the District and their partners permission for reasonable and proper use of any photograph or video taken of me or my child or any written or verbal statement made by me or my child during or pertaining to a facility visit or program.

If any of the above waivers are not initialed, please give reason (please understand that this may prevent your child from participating in this camp):

_____

_____

_____

I have read and understand these policies:

Parent/Guardian Signature: _____ **Date:** _____

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: _____ **Date of birth:** _____

Parent/guardian: _____

Required vaccines

	Immunization date(s) MM/DD/YY						**Titer date*** MM/DD/YY
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella - date of disease		**Varicella** – positive screen date	

*A positive laboratory titer report must be provided to the school to document immunity.

Recommended vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							

Health care provider signature or stamp: _____ Date: _____

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____ Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

Child Release Waiver

Our day camps conduct a sign in and sign out procedure with all children participating in any Full Day Camp to ensure to the extent reasonably possible that all children have a safe and secure experience. Adults authorized by each parent are expected to sign out and return children from camp to their home.

I am requesting that my child be released from camp without adult supervision and be allowed to travel to and from his / her destination (whether by walking, biking or other) on his / her own. I understand that W.E.C.M.R.D cannot be responsible for my child's care or safety once he/ she leaves the program site. There are various dangers that exist between camps and my child's destination including among other vehicular traffic, being lost or abducted, environmental hazards and injury from unsupervised activities. I also understand that W.E.C.M.R.D had not investigated or made any evaluation of the circumstances regarding the reasonableness of my plan for my child reaching his / her destination, including among others my child maturity and the location of his / her destination in relation to W.E.C.M.R.D from any and all responsibility and liability for my child after his /her departure from the W.E.C.M.R.D full day camp programs.

☐ **I request that my child, who is 8 years or older, be allowed to sign his/herself in at the BEGINNING of the regular program time (7:30am – 9:00am)**

☐ **I request that my child, who is 8 years or older, be released on his / her own responsibility at the END of the regular program time (4:30pm – 5:30pm)**

☐ **I am requesting that someone between the age of 12 – 17 years old sign my child at the end of the regular program time (4:30pm – 5:30pm). This underage person who I am requesting to pick up my child is: PRINTED NAME: _____**

Camper Name: _____

Parent Name: _____

Parent Signature: _____ Date: _____

Medication Administration

The Parent / Guardian of _____ ask that W.E.C.M.R.D staff give the following medication _____ at _____ times to my child, according to the health care provider's signed instructions on the lower part of this form. The program agrees to administer medication prescribed by a licensed health care provider. It is the parent' guardian's responsibility to furnish the medication. The parent agrees to pick up expired or unused medication within one week of notification by staff.

PRESCRIPTION MEDICATIONS: must come in a container labeled with; child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.
OVER THE COUNTER MEDICATIONS: must be labeled with child's name/ Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or schools staff delegated to administer medication.

_____ _____ _____
Parent /Legal Guardian Name Parent / Legal Guardian Signature Date

_____ _____
Work Phone Home Phone

Health Care Provider Authorization to Administer Medication in Child Care

Child's Name: _____ DOB: _____

Purpose of Medication: _____

Start Date: _____ End Date: _____ Medication: _____

Dosage: _____ Route: _____

Special Instructions: _____

_____

Side effects that need to be reported: _____

_____ _____
Signature of Health Care Provider w/ Prescriptive Authority License Number

_____ _____
Phone Number Date

PLEASE ASK THE PHARMACIST FOR A SEPARATE MEDICINE BOTTLE TO KEEP AT CHILD CARE
THANK YOU