

Town of Forestport Summer Recreation Program Waiver Form

PLEASE READ CAREFULLY

The undersigned, being the parent or legal guardian of the child listed on this form, understands that the child must be between the ages of **5** and 12 years of age for enrollment in the Program. It is further understood that legal proof of age must be provided for enrollment in this program.

I consent to my child (name) _____'s attendance in the Program. I certify that he/she is in good health, has had a physical examination within the last calendar year, and is able to participate in all activities. I (am, am not) attaching a note explaining any special physical or mental limitation(s) and/or medication(s), if any, which would restrict my child from participating in any activity. In addition, as parent or legal guardian, I authorize Town of Forestport employees to obtain medical treatment for my child as may be necessary.

I understand the risks involved in my child participating in the Program. In consideration of my child's attendance and participation in the Program, and knowing the dangers, hazards and risks thereof, the undersigned, for themselves, any other parent and child, understands and agrees to **RELEASE AND HOLD HARMLESS** the Town of Forestport and its employees from any and all liability for injury, illness, whether mental or physical, and damages resulting from my child's attendance and participation in the Program.

Additionally, the Town of Forestport reserves the right to dismiss any child whose conduct or behavior is harmful to the best interests of the Program or other participants. It is understood that if any child causes the Town of Forestport to believe that the child may cause injury to him/herself or others, the Town of Forestport will notify the child's parent or guardian immediately and may restrict or dismiss that child from further participation in the Program. **Children should be dropped off at the program no earlier than 8:50 and picked up promptly at 12:00. Early drop-offs or late pickups are strictly prohibited. Two violations of this policy will result in expulsion from the program.**

It is understood that all photography and videography taken at the Program may be used for promotional purposes.

In the event that this agreement is executed by one parent (or guardian), the undersigned acknowledges that he/she is also acting as the agent of the other parent (or guardian) with authority to enroll his/her child in the Program and to execute this agreement on his or her behalf. It is understood and agreed that any legal restrictions barring a parent, guardian, or other individual from having contact with the child must be made known to the Program upon enrollment and prior to attending any Program activities.

I have read the Enrollment Agreement and understand its terms and accept its conditions.

Child's Name: _____

Parent or Guardian (Please

Print): _____

Parent or Guardian (Signature): _____

Date: _____

*A parent or legal guardian must provide advance written authorization in order for the Program to release the child to any other person than the parent or guardian. No child will be released to any person other than a parent or guardian without such authorization on file.

Emergency Medical Information Form

Name _____ Address _____

City _____ State _____ Zip Code _____ Home phone _____

Work phone _____ Cell phone _____ Email _____

Date of Birth _____ (keep this information secure) Blood Type _____

Prior transfusion reaction (describe) _____

Please check all that apply:

Contact lenses _____ Dentures _____ Diabetic _____ Epileptic _____ Metal in body _____

Additional information: _____

Allergies to medications? _____ Please list _____

List all medical conditions: _____

List Dietary Restrictions: _____

List all surgeries and hospitalizations:

Year	Surgery Performed/Reason for Hospitalization	Location

OVER →

Additional physicians/specialists:

Physician Name _____ Phone _____ Specialty: _____

Physician Name _____ Phone _____ Specialty: _____

Physician Name _____ Phone _____ Specialty: _____

Case Manager or Social Worker Information:

Name _____ Agency _____ Agency Phone # _____

Next of kin or person to be notified in an emergency:

Name _____ Relationship _____ Phone _____

Email _____

Name _____ Relationship _____ Phone _____

Email _____

Name _____ Relationship _____ Phone _____

Email _____

Name _____ Relationship _____ Phone _____

Email _____

Pharmacy phone _____

Medication List *Include over-the-counter, vitamins and prescription medications*[illegible]