TOWN OF ROYALTON RECREATION REGISTRATION FORM

Recreation Fees: $ 50.00 per child for the five (5) week program

PROGRAM SITE: VETERANS PARK – 7992 State Street, Gasport, NY 14067

ATTENTION: All families must submit a Copy of each child's CURRENT IMMUNIZATION RECORDS prior to participating in the Recreation Program.

Name: _____ Date of Birth: _____ Age: _____
*Copy of Birth Certificate required for five-year-olds

Address: _____ City/State/Zip: _____

Parent/Guardian Name: _____ Phone#: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Phone#: _____ Relationship: _____

MEDICAL INFORMATION:

Allergies _____ Medications _____

Medical Conditions: _____ Restrictions: _____

Doctor's Name: _____ Preferred Hospital (if necessary _____

WAIVERS

SUNSCREEN and/or INSECT REPELLANT WAIVER:

I will provide my child with daily sunscreen and/or insect repellant in a labeled container with his/her name. I give my child, _____ permission to self-administer his/her sunscreen and/or insect repellant (SPF Level ___)

Parent Signature: _____ Print Parent Name: _____

PERMISSION WAIVER

I give permission for my child, _____, to participate in the Town of Royalton Recreation Program. I understand and hereby release and forever discharge any and all rights against the Town of Royalton, the Recreation Committee, the Recreation Director, Site Leaders and Counselors, all employees of the Town of Royalton for injuries to the above-named person or properties during any activity related to participation in the Recreation Program.

I **ACKNOWLEDGE THAT IT IS MY RESPONSIBILITY TO REVIEW AND ENFORCE THE RULES AND REGULATIONS OF THE PROGRAM WITH MY CHILD.**

Date: _____

Parent/Guardian Signature: _____

Office Use Only

Fee Paid: Registration (_)
Field Trips: ( ) # **of trips** _____
Cash or Check # Total Paid: $ _____
Employee's Initials: _____

TOWN OF ROYALTON PERMISSION FORM

PERMISSION TO SIGN IN

I give permission for my child, _____to sign himself/herself in and/or out for a record of daily attendance at the Royalton Recreation Program.

I give permission for the following individuals to sign my child in and/or out for a record of daily attendance at the Royalton Recreation Program.

_____

_____

_____

_____

_____

Parents Name (Print): _____

Parents Signature: _____

Date: _____

****

PERMISSION TO RIDE BIKE

My child has permission to ride his / her bike to and from the Royalton Recreation Program.

YES NO Parents Signature: _____

** **FOR SAFETY REASONS - CHILDREN ARE REQUIRED TO WEAR A HELMET TO AND FROM RECREATION****

****

VOLUNTEERS/CHAPERONES

Are you interested in volunteering to chaperone our weekly field trips? YES ___ NO ___

If Yes, please supply the following information:

Full Name: _____

Current Address: _____

_____

_____

Date of Birth: _____

This information is necessary to perform a Required NYS Background Check prior to approval.

TOWN OF ROYALTON RECREATION

Recreation Counselors CANNOT ADMINISTER MEDICATION. All children must be considered Self-Administering of all prescription/non-prescription or topicals (including sunscreen, insect repellant, and lotion).

Guidelines for Medication at Recreation

Parents should be aware of the strict guidelines established by the State of New York for medication in schools and recreation facilities. The State cautions about over-medication in our society but recognizes that in certain circumstances medication for individual students must be available under specific conditions. These rules must be strictly adhered to. If your child needs medication on a daily basis, please see if medication times can be before or after Recreation.

Prescription, Non-Prescription (over-the-counter medications) & Topicals

***Please note: Your child must be able to self-administer all the above-mentioned. A script from the doctor must relay such information. Your cooperation is greatly appreciated and expected.**

1. The off-site/on-site Health Director must have a written request from the child's physician that indicates the name, frequency, dosage, route, and side effects of the medication. In addition, the condition being treated and the length of time the medication is to be administered are to be specified by the physician.

2. The off-site/on-site Health Director must have a written request from the parent to administer the medication as specified by the physician. A verbal or telephone request is not adequate.

3. Both types of medications must be either in the container prepared by the pharmacist or the original OTC medication bottle. Both containers must include the name and strength of the medication. (NOTE: The pharmacy label does not constitute a written order and ***cannot*** be used in lieu of a written order from licensed prescriber.) When having prescriptions filled, parents should request two containers one (1) for home and one (1) for recreation.

4. All medication must be delivered directly to the on-site Health Director by the parents or adult designee. **NO MEDICATION SHOULD BE SENT TO RECREATION WITH THE CHILD. NO MEDICATION IS PERMITTED TO BE CARRIED ON A FIELD TRIP WITHOUT PRE-APPROVAL.**

5. Medication orders must be renewed annually or when there is any change.

6. All medication will be kept in a locked, secure cabinet. However, some children may carry personal emergency medical supplies as prescribed by physicians.

If there are any questions regarding this matter, please do not hesitate to contact your child's Recreation Director and/or the Niagara County Health Department.

TOWN OF ROYALTON

INDIVIDUAL HEALTH RECORD & MEDICAL PERMIT

NAME: _____ DATE OF BIRTH: _____

HOME ADDRESS: _____

PARENT/GUARDIAN: _____

HOME PHONE: _____ CELLPHONE: _____

EMERGENCY CONTACT: _____

PHONE NUMBER: _____

FAMILY PHYSICIAN: _____

FAMILY MEDICAL / HOSPITAL INSURANCE CARRIER: _____

POLICY NUMBER: _____

DATE OF LAST HEAL TH EXAMINATION: _____

DATE OF LAST TETANUM IMMUNIZATION: _____

ILLNESS AND INJURIES

___ ASTHMA ___ DIABETES ___ BLEEDING/CLOTTING DISORDER

___ SEIZURES ___ HYPERTENSION ___ HEART DEFECT/DISEASE

___ OTHER (SPECIFY) ___ MUSCULOSKELETAL DISORDERS

_____

OPERATIONS AND OR SERIOUS INJURIES (WITH DATES)

_____

_____

_____

ALLERGIES

___ ANIMALS ___FOOD ___ HAY FEVER ___ INSECT STINGS

___ MEDICINE ___PLANTS ___ POLLEN ___ SUN

___ OTHER (SPECIFY) _____

TOWN OF ROYALTON
INDIVIDUAL HEALTH RECORD AND MEDICAL PERMIT

OTHER HEALTH CONDITIONS

___ **EMOTIONAL DISTURBANCES** ___ **MENSTRUAL CRAMPS** ___ **FAINTING**

___ **HEARING IMPAIRMENT** ___ **CONTACT LENSES** ___ **GLASSES**

___ **OTHER (SPECIFY)** _____

Please explain all items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also indicate any activities to be restricted:

_____

_____

_____

MEDICATIONS

Please list all medications participant is currently taking and for what reason:

_____

_____

_____

MEDICAL ATTENTION AUTHORIZATION

In an EMERGENCY, should it happen that we, the parents and/or guardians of _____ cannot be located promptly, I HEREBY AUTHORIZE THE REPRESENTATIVE/SUPERVISING ADULT (coach or site leader) of the TOWN OF ROYALTON SUMMER RECREATION PROGRAM to be my (our) agent in authorizing any hospital/physician deemed advisable by, and rendered under the general supervision of any licensed medical doctor on the staff of any hospital for my child/legal ward or myself.

EFFECTIVE DATE: FROM: _____ TO: _____

Signature of parent/guardian and/or adult participant:

_____ DATE: _____

***NOTE: If there is religious opposition to medical treatment or immunization, you must supply a written statement indicating the religious beliefs. This statement must be signed and dated.**

THIS FORM MUST BE IN THE POSSESSION OF THE SUPERVISING ADULT AT ALL TOWN OF ROYALTON SUMMER RECREATION PROGRAM ACTIVITIES IN CASE OF A MEDICAL EMERGENCY!

TOWN OF ROYALTON RECREATION

PARENT AND PRESCRIBERS AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION AT RECREATION

To be completed by the Parent or Guardian:

I request that my child _____, age ____ , be authorized to self-administer medication at the Town of Royalton Recreation Program as prescribed below by our licensed health care prescriber. The medication is to be furnished by me (medications may only be delivered and picked up by an adult) in the properly labeled original container form the pharmacy. ***I understand that counselors cannot administer medication, they can only observe while my child takes his/her own medication.*** The order is honored for this recreation season only. Separate requirements are required by law for medications to be taken on any trips and contact with the Recreation Director will be necessary.

I understand also that a child who is self-directed can carry and self-administer medication for asthma, severe allergic conditions and diabetes. ***A script is also necessary for such situations.***

Signature (Parent or Guardian): _____

Address: _____

Phone #'s Home: _____ Work: _____ Cell: _____ Other: _____

****

To be completed by the Physician or Medication Subscriber:

I request that my patient, as listed below, receives, and can self-administer the following:

Name of Student: _____ Date of Birth: _____

Age: _____ Diagnosis: _____

Name of Medication: _____ Duration of Treatment: _____

Prescribed dose, route, frequency & time of medication administration: _____

_____

Possible side effects & adverse reaction for which to be monitored: _____

_____

Measures to be taken if side effects or adverse reaction noted: _____

Other recommendations: _____

Name of Licensed Prescriber and Title (please print or stamp): _____

Prescriber's Signature: _____ Date: _____

Address: _____

Phone #: _____ Fax #: _____