Day Camp Participant Records

Dates of Attendance: ____

Name: ______________________________________ DOB:______AGE: ____ Gender:___

(Last) (First) HAIR COLOR: _______EYE COLOR: ________

Address:____

Street City State ZIP

Mother/Guardian: ____

Last First

Address: (if different from child): ____

Phone: __________________________________ Cell: ___________________________

Employer: ______________________ Address: ____________________Phone: ____________

Father/Guardian: ____

Last First

Address: (if different from Child) ____

Employer: ______________________Address: ____________________Phone: ____________

Alternate Emergency Contact: ____

Last First

Relationship to child: ______________________Address: ____________________________

Phone: _____________(home), ______________(cell), _______________(work)

People authorized to pick up child: ***MUST INCLUDE ADDRESSES AND PHONE NUMBERS***

Name: ____

Address: _______________________________ Phone: ________________________

Name: ____

Address: _______________________________Phone: ________________________

Doctor: ____________________________________ Phone: _______________

Address: ____

Dentist: ____________________________________ Phone: _______________

Address: ____

Hospital: ___________________________________Phone: _______________

Address: ____

MUST INCLUDE ADDRESSES AND PHONE NUMBERS

Health Record:

History (chronic or recurring):

Ear Infections ______ Diabetes _____ Heart Disease/Defect ____ Convulsions/Seizures ____ Nose Bleeds ____ Other ____

ALLERGIES: (Specify nature and reactions)

Hay Fever: ____________________ Insect stings/bites: __________________Drug Allergies: __________

Food Allergies: ___________________________ Other: ______________________________________

Physical Limitations: _____yes _____ no If yes, please explain: ______________________________

Dietary Limitations: _____ yes _____ no If yes, please explain: ______________________________

Behavior considerations: _____ yes _____ no If yes, please explain: ___________________________

Vision considerations:__________________________ Hearing considerations: __________________

IMMUNIZATION CARD ATTACHED: _____YES _____NO

DATE OF LAST PHYSICAL EXAM: ____

PARENT/GUARDIAN AUTHORIZATION FOR DAY CAMP PARTICIPATION

Child's Name ____

The aforementioned health history is correct and I understand that no Medication will be administered unless "Medication Authorization Sheet" is obtained, completed, signed by both the authorized physician and the parent/guardian and returned to Day Camp Staff. In the event that emergency medication is needed, child cannot be left at camp until all forms are received with the medication.

I hereby give permission for the City of Northglenn Day Camp Staff to call for emergency medical care from a doctor, hospital or medical services to provide medical or surgical care for the above named child should an emergency arise. It is understood that the camp staff will make a conscientious effort to contact parents or emergency contacts listed on this form when emergency action is taken.

I give permission for City of Northglenn Day Camp Staff to administer sunscreen to my child in the event that they are not able to do so themselves. Sunscreen will provided for planned outdoor activities. SPF 50 will be available.

The person described herein has my permission to participate and engage in all camp activities (which may include swimming, skating, bowling, pedal boating, field trips and other activities which may involve certain risks) except as otherwise noted here: ______________________________. Transportation will be provided by Adams County Dist. 12 or City 15 passenger van. All rules and regulations regarding bus transportation will be given by bus drivers.

I agree to take full responsibility for my child or ward. I agree to indemnify and hold the City of Northglenn and all auxiliary cooperating agencies involved the activities and any other servants, agents, or employees free and harmless from any liability, loss, cost or expense including attorney's fee which may result from participation in such activities. I agree to be solely responsible for payment of all costs associated with Day Camp participation and all costs resulting from rendering of medical aid and /or ambulance service prescribed by qualified personnel.

I have received and read and understand the rules, guidelines, procedures and policies. I have gone over the material with my child/ren and we agree to follow such as described in the parent information materials. By signing below I agree that I understand the statements made above and consent to the statements.

____

Parent Signature　　　　　　　　　　　　　　　　　　　　Date

____

Printed Name

COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH STUDENT ATTENDING COLORADO SCHOOLS

Name________________________ Date of Birth ________________________

Parent/Guardian ________________________

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION

Vaccine		Enter the month, day and year each immunization was given					
Hep B	Hepatitis B						
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)						
DT	Diphtheria, Tetanus (pediatric)						
Tdap	Tetanus, Diphtheria, Pertussis						
Td	Tetanus, Diphtheria						
Hib	*Haemophilus influenzae* type b						
IPV/OPV	Polio						
PCV	Pneumococcal Conjugate						
MMR	Measles, Mumps, Rubella						
Varicella	Chickenpox			Healthcare Provider Documentation Date ______		Lab Verification Date ______	
Vaccines recorded below this line are recommended. Recording of dates is encouraged.							
HPV	Human Papillomavirus						
Rota	Rotavirus						
MCV4/MPSV4	Meningococcal						
Hep A	Hepatitis A						
TIV/LAIV	Influenza						
Other							

THIS SECTION CAN BE COMPLETED BY CHILD CARE/SCHOOL/HEALTH CARE PROVIDER

☐ **A) Child Care Up to Date**
Up to date through 6 months of age for Colorado School Immunization Requirements — Update Signature ______ Date ______

☐ **B) Child Care Up to Date**
Up to date through 18 months of age for Colorado School Immunization Requirements — Update Signature ______ Date ______

☐ **C) Child Care/Pre-school/Pre-K***
Up to date for Child Care/Pre-School/Pre-K for Colorado School Immunization Requirements — Update Signature ______ Date ______

☐ **D) Complete for K–5th Grade**
Up to date for K–5th Grade for Colorado School Immunization Requirements — Update Signature ______ Date ______

* If age 4 years and fulfills Requirements for Pre-School & Kindergarten, check BOTH Boxes C and D.

HAS MET ALL IMMUNIZATION REQUIREMENTS FOR COLORADO SCHOOLS (6TH GRADE OR HIGHER)

Signed ________________________ Title ________________________ Date ______________
(Physician, nurse, or school health authority)

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW (DECLARACIÓN RESPECTO A LAS EXENCIONES DE LA LEY DE VACUNACIÓN)

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.
SI SE PRESENTA UN BROTE DE LA ENFERMEDAD, ES POSIBLE QUE A LAS PERSONAS EXENTAS SE LES PONGA EN CUARENTENA O SE LES EXCLUYA DE LA ESCUELA.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.
EXENCIÓN POR RAZONES MÉDICAS: El estado de salud de la persona arriba citada es tal que la vacunación significa un riesgo para su salud o incluso su vida; o bien, las vacunas están contraindicadas debido a otros problemas de salud.

***Medical exemption** to the following vaccine(s):*
***La exención por razones médicas** aplica a la(s) siguiente(s) vacuna(s):*

Signed (Firma) ________________________ Date (Fecha) ____________
Physician (Médico)

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.
EXENCIÓN POR MOTIVOS RELIGIOSOS: El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religión que se opone a la inmunización.

***Religious exemption** to the following vaccine(s):*
***Exención por motivos religiosos** de la(s) siguiente(s) vacuna(s):*

Signed (Firma) ________________________ Date (Fecha) ____________
Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.
EXENCIÓN POR CREENCIAS PERSONALES: Las creencias personales del padre o tutor de la persona arriba citada, o la persona misma, se oponen a la inmunización.

***Personal exemption** to the following vaccine(s):*
***Exención por creencias personales** de la(s) siguiente(s) vacuna(s):*

Signed (Firma) ________________________ Date (Fecha) ____________
Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR