

City of Northglenn  
Roving Rec. on the Road 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:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Doctor:** \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Dentist:** \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Hospital:** \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**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**

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 Roving Rec. 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 Roving Rec. 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 Roving Rec. 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 30 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 Roving Rec. on the Road 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.

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Parent Signature Date

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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
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	

Healthcare Provider Documentation Date \_\_\_\_\_ Lab Verification Date \_\_\_\_\_

**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