



FOR SCHOOL USE ONLY: # \_\_\_\_\_

DATE AND TIME SUBMITTED: \_\_\_\_\_

# STEP CAMP REGISTRATION FORM

**Please complete all three (3) pages of this form in INK.**

Elementary  Fruit Valley  Hough  Washington  Lincoln  Franklin  Harney  Other School:

Name of Participant: \_\_\_\_\_ Parent/Guardian's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Participant's Information: Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Shirt Size: \_\_\_\_\_

Disabilities / Significant Illness / Behavioral Issues: \_\_\_\_\_

Allergies: \_\_\_\_\_

Fears: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Parent / Guardian, please provide at least 2 contact numbers where you can be reached during program hours:

1) Home: \_\_\_\_\_ 2) Work: \_\_\_\_\_ 3) Cell/Other: \_\_\_\_\_

**Persons to be notified in case of emergency (other than parent/guardian) and persons allowed to pick up your child**

<u>Name</u>	<u>Contact Numbers</u>	<u>Relationship to Participant</u>	<u>Authorized to Pick up (Y/N)</u>
_____	_____	_____	_____
_____	_____	_____	_____

**TRANSPORTATION TO/FROM PROGRAM**

Please choose only **one**:  Walk  Pick-up/Drop-off  Other: \_\_\_\_\_

**Persons authorized to pick up my child in my absence.**

<u>Name</u>	<u>Contact Numbers</u>	<u>Relationship to Participant</u>
_____	_____	_____
_____	_____	_____

**STAFF WILL NOT RELEASE THE PARTICIPANT TO ANY PERSON NOT LISTED ON THIS FORM!**

I the undersigned, permit the individuals I have authorized above, to pick up my child in my absence. I understand that if one of the above-named individuals is authorized to pick up my child and staff members have not previously met the individual, they will be requested to show photo identification prior to release of the child.

X \_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**CONSENT TO BE PHOTOGRAPHED**

I consent and authorize the fruit Valley Foundation to use my/our child's name and photograph for public relations purposes related to the STEP Camp.

X \_\_\_\_\_  
Signature of Parent/Guardian Date

\_\_\_\_\_  
Print Name

No, please do not use my child's image

**CONSENT FOR VANCOUVER SCHOOL DISTRICT TO RELEASE DATA TO FRUIT VALLEY FOUNDATION**

I authorize Vancouver School District to release information specific to my child's academic and behavioral performance to the Fruit Valley Foundation solely for the purposes of evaluating and justifying the STEP Camp. Such information will not be shared by Fruit Valley Foundation in any way that indentifies my child specifically.

X \_\_\_\_\_  
Signature of Parent/Guardian Date

\_\_\_\_\_  
Print Name

No, please do not release my child's data

**CONSENT TO PARTICIPATE AND HOLD HARMLESS**

I, the undersigned, state that I am the parent or legal guardian of above-named child. I hereby request that the Fruit Valley Foundation allow my/our child to participate in STEP Camp and all associated activities, including field trips.

I hereby state that I am voluntarily allowing my/our child to participate in this program and that I recognize that there are certain risks and dangers inherent in their participation in this type of activity.

I understand the Fruit Valley Foundation cannot and does not guarantee or insure the safety of my/our child. I am willing to assume any risk, on behalf of myself/ourselves alone, of personal injury or property damage to my/our child in order to allow him/her to participate in this program, except that caused by the sole negligence of the Fruit Valley Foundation. I therefore release, the Fruit Valley Foundation, its officials, administrators, employees and volunteers from all liability, claims and causes of actions arising or in any way connected with my/our child's participation in the above-named program, except that caused by the sole negligence of the Fruit Valley Foundation.

In consideration of the Fruit Valley Foundation allowing my/our child to participate in this program, I hereby agree to release, hold harmless, and defend the Fruit Valley Foundation, and its officials, administrators, employees and agents from any and all claims for damages or injury to my/our child arising out or in any way connected with my/our child's participation in the above-named program, except that caused by the sole negligence of the Fruit Valley Foundation.

**I CERTIFY THAT I HAVE READ THE FOREGOING AND AGREE TO ALL THE TERMS AND CONDITIONS OF THIS AGREEMENT.**

X \_\_\_\_\_  
Signature of Parent/Guardian Date

\_\_\_\_\_  
Print Name

**PARTICIPANT'S MEDICAL INFORMATION AND RELEASE**

I certify that the above-named participant is in good health and able to participate in all activities:

Yes  No *If NO, please specify limits of participation:* \_\_\_\_\_

Is the participant allergic to any food or medication?

Yes  No *If YES, please specify:* \_\_\_\_\_

Is the participant currently under health care guidance for the following:

Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	ADHD/ADD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Counseling	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other condition or special care needs (*specify*): \_\_\_\_\_

Current Medication(s) \_\_\_\_\_ Date of last Tetanus shot \_\_\_\_\_

*Group leaders must be informed of any prescription medication brought by youth, with clear information as to proper use and dosage. If medication is "as needed", your child must understand the symptoms of their condition and know when to ask for help. If your child needs medication and/or extra staff assistance during program hours, please contact the coordinator for the appropriate forms and/or procedures. Staff and Volunteers CANNOT administer medication.*

Please, check which over-the-counter medications you will NOT allow to be dispensed to this participant:

<input type="checkbox"/> Benedryl	<input type="checkbox"/> Acetaminiphen (e.g. Tylenol)	<input type="checkbox"/> Nasal Decongestant (e.g. Sudafed)
<input type="checkbox"/> Pepto Bismol	<input type="checkbox"/> Ibuprofen (e.g. Advil, Motrin)	<input type="checkbox"/> Cough Suppressant (e.g. Robitussin)

Family Physician (*name*): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insurance (*company & policy number*): \_\_\_\_\_

Phone # to verify coverage or submit claim: \_\_\_\_\_ Policyholder's name: \_\_\_\_\_

**About Insurance Cards – It Could Be Important!**

A hospital may require a Social Security number and/or insurance card as proof of insurance) before treatment or admittance. You should make sure the participant carries that information to events, or you can provide that information here:

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ or **attach copies (front and back) of insurance card to this form.**

As the legal guardian of the above-named participant, I hereby attest that I have read this complete document; all information provided is complete and true; I have legal standing to make decisions which affect the rights of the above named participant; and I understand and consent to all terms outlined in this document. I hereby voluntarily and knowingly assume all risks and dangers inherent and incidental to Fruit Valley Foundation activities and travel understanding that some activities may pose a risk of injury. I will not hold liable the Foundation, their volunteers, agents and event/youth group leaders for any injury, illness or property damage involving the above-named participant no matter how caused. Whenever deemed necessary by group leaders, I authorize the calling of a doctor and/or the providing of other medical services and, unless covered by insurance, agree to pay for same. If the above-named participant is incapacitated, I do hereby authorize group leaders as agent for the undersigned, to consent with respect to such participant to any x-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment, and hospital care which is deemed advisable by a state-licensed physician or surgeon.

X \_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name