

## AFTER SCHOOL PROGRAM/DAY CAMP/ TEEN REGISTRATION & MEDICAL INFORMATION

**Complete and turn in to your preferred Community Center.**

- After School Program                       Day Camp                       Teens  
 Arnold Rue     Seifert     Stribley     Van Buskirk     John Muir (John Muir students ONLY)

Participant's Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_ Gender:  M  F

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Attending School : \_\_\_\_\_ Grade: \_\_\_\_\_

INSURANCE CARRIER: \_\_\_\_\_ I.D.#: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Parent/Guardian 1: _____
Home # _____
Cell # _____
Work # _____
Email _____
DOB _____

Parent/Guardian 2: _____
Home # _____
Cell # _____
Work # _____
Email _____
DOB _____

Children must be signed in/out daily by the parents/guardians listed above or assigned individuals below. Individuals listed below must be 18 years of age and possess a valid drivers license and will be required to show their drivers license. LATE FEE: \$15 fee per 15 minutes late, will be charged for late pick-ups. No exceptions. NOTE: Persons listed below may be called in an emergency situation if parent(s)/ guardian(s) are not available.

**ASSIGNED DROP-OFF/PICK-UP INDIVIDUALS:**

Name	Relationship	Home/Cell Phone	Work Phone

**Please provide any other information that will assist staff in making your child(ren) have the best experience: \_\_\_\_\_**

\_\_\_\_\_

\_\_\_\_\_

**PARENT/GUARDIAN CONSENT OF WAIVER FOR PARTICIPATION:** In return for being permitted to participate in the program/activity listed on this form (the "Program"), including any associated use of the premises, facilities, staff, equipment, transportation, and services of the City, I, for myself, heirs, personal representatives, and assigns, do hereby release, waive, discharge, and promise not to sue the City of Stockton, its officers, employees, agents, and contractors (the "City"), from liability from any and all claims from whatever cause, including the negligence of the City, resulting in personal injury (including death), illness (of any type, including communicable diseases such as MRSA, influenza, and COVID-19), and property loss, in connection with my participation in the Program and any use of City premises and facilities. **Indemnification and Hold Harmless:** I also agree to hold harmless, defend, and indemnify the City from and against any and all liability, loss, damage, expense, costs (including without limitation costs and fees of litigation) of every nature arising out of or in connection with my involvement in the Program, and to reimburse City for any such expenses incurred. **Images:** I understand that by participating in the Program, I give consent for images of myself taken at the Program to be used for promotional or instructional purposes by the City. **Cancellation:** In the case of an emergency, or for reasons beyond the City's control, the City reserves the right to cancel the Program prior to its commencement without liability. Refunds will be made accordingly. **Severability:** I further agree that this RELEASE is intended to be as broad and inclusive as permitted by law, and that if any portion is held invalid the remaining portions will continue to have full legal force and effect.

I have read this RELEASE and understand that I am giving up substantial rights, including my right to sue. I confirm that I am signing this document freely and voluntarily, and intend my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PLEASE COMPLETE THE MEDICAL INFORMATION ON THE BACK SIDE OF THIS FORM**

FOR OFFICE USE ONLY: DATE RECEIVED: \_\_\_\_\_

FEE ENCLOSED: \_\_\_\_\_



## AFTER SCHOOL EXPRESS/DAY CAMP REGISTRATION/MEDICAL INFORMATION FORM

The City of Stockton is concerned for the health, safety and inclusion of all children in its care. Accordingly, when a parent(s)/guardian(s) is registering their child in a City of Stockton recreation program we like to have as much information about each child to ensure their experience is as safe and memorable as possible. Please fill out the following health information to assist us. We encourage each parent/guardian to speak with Community Center Staff prior to the start of the program for any questions, or if more information needs to be provided about their child(ren). All information will be kept confidential.

### HEALTH & MEDICAL INFORMATION (Please check ALL that apply)

<input type="checkbox"/> Asthma/Respiratory Condition	<input type="checkbox"/> Attention Deficit Disorder
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hearing Impaired
<input type="checkbox"/> Sun Burns Easily	<input type="checkbox"/> Uses Epi-pen
<input type="checkbox"/> Unusual Bleeding	<input type="checkbox"/> Vision Impaired

**Seizures**                       Yes    No                      **Type & Frequency** \_\_\_\_\_  
 \_\_\_\_\_

**Bee Sting Allergy**                       Yes    No                      **Reaction** \_\_\_\_\_  
 \_\_\_\_\_

**Food Allergies**                       Yes    No                      **List Foods & Reaction** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medication Allergies**                       Yes    No                      **List Meds & Reaction** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Other Conditions: (Please Explain)**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Does the child have a disability requiring any accommodations?  
 If yes, please explain  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Children must be able to monitor and administer their own medication.  
 Is your child taking any medication?    Yes    No  
 List Medication/Reason/Dosage/Interval:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_