



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

Program Location: \_\_\_\_\_

**PARTICIPANT INFORMATION FORM**

*You must fill out both sides of this form and bring it with you on the first day of the activity.*

**General Information:** (Please Print)

Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Grade entering in fall: \_\_\_\_\_

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

**Individual(s) to be contacted in case of emergency:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Person (other than parent) authorized to drop off / pick up participant:**

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Are there any custody issues we should be aware of?  No  Yes (if yes, attach a copy of court order)

**Health issues and special accommodations:**

Are there any health concerns that our staff should be aware of? (asthma, allergies, hypoglycemia, seizure disorder, etc.)  No  Yes (if yes, please specify) \_\_\_\_\_

What symptoms would your child exhibit? \_\_\_\_\_

\_\_\_\_\_

Requested actions to be taken by staff: \_\_\_\_\_

\_\_\_\_\_

Please indicate any of the following health problems or disability: (please check all that apply)

- Deaf / hard of hearing
- Seizures
- Development disability (i.e. autism, intellectual, etc.)
- Other (i.e. behavioral / emotional disorder, etc.) \_\_\_\_\_
- Vision impairment
- Uses mobility aids (i.e. wheelchair, braces, etc.)

Please explain any specific health issues or accommodations needed to participate in program:

- Inclusion Companion
- Other (please specify) \_\_\_\_\_
- Deaf interpretive services

**Medication:**

Is the participant taking any medication?  No  Yes

Will participant need to take medication during program hours?  No  Yes

(if yes, attach a Medication Authorization Form; available from HCRP office or online at <http://www.howardcountymd.gov/rap/medicationform.pdf>)

**Sunscreen is considered a topical medication.**

Parents wishing their child to apply sunscreen at camp, complete information below:

Brand of sunscreen: \_\_\_\_\_

Specific directions for application: \_\_\_\_\_

**Information required by state regulations (for Summer Camps only):**

Child's School: \_\_\_\_\_  MD Public/Private School  Other

My child's immunizations are up to date.  No  Yes

Date of last tetanus: \_\_\_\_\_  Unknown

Participant's Primary Physician: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

**I understand:**

1. By registering for this program, I verify that my child's immunizations are up to date.
2. That there are inherent dangers in any recreational activity, program or camp.
3. That I must be aware of the hazards associated with each activity, such as use of equipment, slips and falls, personal level of fitness, training, and various athletic injuries.
4. I must read and understand all written material, which has been provided by the Howard County Department of Recreation and Parks.
5. The rules and regulations for each activity, as explained in any written materials and/or explained by staff.
6. That the possible consequences of participating in these activities include the possibility of serious injury.

**I agree:**

1. To obey the rules and regulations for each activity and to follow the directions of the staff.
2. To inform a staff member of any dangerous or potentially hazardous situation that I may observe.
3. That if I do not understand how an activity is performed or how a piece of equipment is to be used, I will ask a staff member prior to beginning that activity.
4. To inform a staff member if I have any problems meeting the physical requirements necessary for participation in any activities.

I am aware that while participating in a recreation activity or program arranged by the Howard County Department of Recreation and Parks, certain risks and dangers may be present, including but not limited to those generally associated with certain activities, the hazards of traveling the public highways, of accidents, of illness, and of those forces of nature.

I agree to indemnify and defend Howard County and hold it harmless from and against any and all claims, suits, damages, liabilities and expenses, including attorney's fees and the County's costs of defense, in connection with loss of life, personal or bodily injury and /or damage to or loss of property that arises from the participation of \_\_\_\_\_ (Name of Participant) in \_\_\_\_\_ (Name of activity or program), except to the extent that such loss or damage is occasioned by the negligent act or omission of the county, its officers, agents or employees and no negligence on the part of the Participant.

In **EMERGENCIES** requiring immediate medical attention, your child will be taken to the **NEAREST HOSPITAL EMERGENCY ROOM**. Your signature authorizes the responsible person at the program to have you or your child transported to that hospital.

Signature of Participant or Parent/Guardian if under 18:

Date: