

Camp Marshalltown

REGISTRATION FORM

Complete and return to Parks & Recreation, 10 W State Street.

Participants Name:		Gender:	Birth Date: / /	Age:
Home Phone ()		Grade Entering:	School Attending:	
Address		City	Zip	
PRIMARY DISABILITIES/DIAGNOSIS:				
PARENT(S)/GUARDIAN(S)				
1. Name		Birth Date / /	Relationship To Child	
Address		Email		
Primary Phone	Cell #	Work #		
2. Name		Birth Date / /	Relationship To Child	
Address		Email		
Primary Phone	Cell #	Work #		

Please inform those listed that a photo ID is required to pick up this participant.

Persons Authorized To Pick Up Participant	Relationship to Participant	PHONE NUMBER
1.		
2.		
3.		
4.		

Are there any custody or restraining orders concerns involving this participant to make known to Camp Marshalltown?

Name	Name
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Circle T-Shirt Size	6-8	10-12	14-16	Adult S	Adult M	Adult L	Adult XL	Adult 2XL
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EMERGENCY CONTACT PERSON(S)				
1. NAME		RELATIONSHIP TO PARTICIPANT		
HOME NUMBER		CELL NUMBER	WORK NUMBER	
2. NAME		RELATIONSHIP TO PARTICIPANT		
HOME NUMBER		CELL NUMBER	WORK NUMBER	

In the event the participant needs medical treatment, I hereby authorize treatment of the above named person by a qualified and licensed health care professional. This authorization is valid only after reasonable effort has been made to contact me.

PHYSICIAN NAME	DENTIST NAME
PHONE NUMBER	PHONE NUMBER
ADDRESS	ADDRESS
HOSPITAL PREFERENCE	
DATE OF LAST TETANUS	
INSURANCE COMPANY	POLICY HOLDER ID

MEDICAL INFORMATION

MEDICATIONS ** If the participant does not have needed medication provided for their day, they cannot stay at camp**

MEDICATION	DOSAGE	FREQUENCY

ALLERGIES

NAME ALLERGY	REACTION	TREATMENT NEEDED

Is the participant subject to seizures? Yes No

If Yes, Is there a specific cause known or suspected?

Seizure Type	Frequency
Are seizures controlled by medications?	Yes No

In the event a seizure occurs at camp, please list steps to be taken (i.e. Call 911, Give Meds, Allow rest & Call parents).

Are there any doctor's restrictions?	Yes	No
If Yes, please describe:		

Does the participant use/wear any of the following?

Contact Lenses	Orthopedic Devices	Dentures
Glasses	Hearing Aid	Prostheses

Other:

MOBILITY INFORMATION

Is the participant ambulatory?	Yes	No
Does the participant use a wheelchair?	Yes	No
Is the participant able to aid in transferring?	Yes	No

If Yes, please explain:

Does the participant use any assistive device? Cane Walker Brace Crutches Other

DIETARY NEEDS

Does the participant have any special diets or dietary restrictions?	Yes	No
If Yes, please explain:		

Is assistance needed with eating?	Yes	No
If Yes, please explain:		

PERSONAL CARE

Does the participant need assistance in the bathroom?	Yes	No
If yes, what assistance is needed?		
Are regular bathroom times needed?	Yes	No
If Yes, please give details?		

Does the participant need assistance during menstruation?	Yes	No
If Yes, please specify:		

Does the participant use sign language	Yes	No
Can the participant read and write?	Yes	No
Are there other communication methods?	Yes	No

SAFETY

Please indicate Yes or No to the following:

Is the participant willing to stay with the group?	Yes	No
Can the participant be responsible for their belongings?	Yes	No
Is the participant able to manage his or her own money while at camp?	Yes	No
Can the participant recognize danger?	Yes	No
Is the participant able to state their name & phone number?	Yes	No
Does the participant sometimes wander or run?	Yes	No

SWIMMING:

Is the participant able to swim?	Yes	No
Does the participant need a life jacket?	Yes	No
Does the participant need 1:1 assistance in the water?	Yes	No
Does the participant need assistance dressing?	Yes	No

Please mark the available areas of use while the participant is at the Aquatic Center.

<input type="checkbox"/> Shallow Water Only	<input type="checkbox"/> Shallow water (lap lanes --5' deep)	<input type="checkbox"/> Lazy River
<input type="checkbox"/> Slides (must be 48" tall)	<input type="checkbox"/> Deep end (diving well & drop slide)	<input type="checkbox"/> All areas, no restrictions

Information about swimming ability or restrictions:**BEHAVIOR/PERSONALITY**

Describe the best way to involve the participant in an activity:

Does the participant have fears or phobias?	Yes	No
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If Yes, please describe:

What activities, settings or triggers might cause behavior difficulties (noises, airplanes, escalators, flashing lights, etc.)?

What is the best way to introduce or explain new activities or transitions?

What things frustrate the participant and how is it best addressed?

What is the best way to redirect the participant?

Does the participant act out?	Yes	No
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If Yes, please explain:

What type of behavior management or reinforcement works best?

Interests/Hobbies

Please give any additional information to help allow the best possible camp experience for this participant.

Parental Permission

1. I/We recognize and agree that as participants or observers I/we shall bear the full responsibility of any loss or theft of personal items while engaging, participating, or observing in these activities.
2. In the event of injury or illness, I hereby give my consent for medical treatment, and permission to program staff for supervising and performing, as deemed necessary by staff, on-site first aid for minor injuries, and for a licensed physician to hospitalize and secure proper treatment (including injections, anesthesia, surgery, or other reasonable and necessary medical or surgical procedures) for me or my participant or observing spouse, if I am unable to provide that consent directly at the time, for any reason. I agree to assume all costs related to any such medical or surgical treatment. I also authorize the disclosure of medical information to my insurance company for the purpose of this claim.

Photo PermissionI authorize the use of photographs or descriptions of me or my child in newspapers, publications, presentations or displays to promote services of Parks & Recreation, Arc of Marshall County or United Way. YES NO**Parent/Guardian**

(Print) _____ Signature _____ Date _____