CHILD'S LAST NAME

CHILDS FIRST NAME

_________ _____________________ ____ M ____ F
AGE DATE OF BIRTH

ALLERGIES? (YES) (NO)
EPI Pen? (YES) (NO)

REGISTRATION FORM

Room # ________________ **Owner or Guest**

Name on Room: ____ Room Charge or Pay Direct at Front Desk

____ ( ) _________-_____________ ( ) _________-_____________
PARENT 1 NAME **PRIMARY #** **SECONDARY #**

PARENT 1 EMPLOYER **WORK PHONE** **PRIMARY EMAIL**

____ ( ) _________-_____________ ( ) _________-_____________
PARENT 2 NAME **PRIMARY #** **SECONDARY #**

PARENT 2 EMPLOYER **WORK PHONE** **PRIMARY EMAIL**

FAMILY & CHILD'S HOME ADDRESS **CITY** **STATE** **ZIP**

FAMILY & CHILD'S PERMANENT MAILING ADDRESS **CITY** **STATE** **ZIP**

EMERGENCY CONTACT INFORMATION & ADDITIONAL PERSONS AUTHORIZED TO PICK UP

1. ____________________________________ _________________________ ( ) ______-__________ ( ) ______-__________
FULL NAME RELATIONSHIP **Primary #** **secondary #**

2. ____________________________________ _________________________ ( ) ______-__________ ( ) ______-__________
FULL NAME RELATIONSHIP **Primary #** **secondary #**

3. ____________________________________ _________________________ ( ) ______-__________ ( ) ______-__________
FULL NAME RELATIONSHIP **Primary #** **secondary #**

DESIRED DATE(S) OF ATTENDANCE: ____

Does your child have a Vail Mountain season pass (or epic pass)? ____ YES ____ No

Health Statement

Is your child in good health? (Y) (N) If no, why? ____
Are there any past or present health problems? (Asthma, frequent headaches, seizure disorder, etc.) (Y) (N)
If yes, explain: ____
Health Insurance Company: ______________________________________ Policy # __________________________
Physician: _______________________ Phone: _______________ Dentist: ____________________ Phone: _______________
Medications: _____________________________________ Emergency Medications: _______________________________
Medical needs, physical challenges, special needs: ____
Allergies/Reactions to Medications: ____
In case of an emergency, serious illness or injury and parents and emergency contacts can not be reached, do you give authorization for camp staff to transport your child to the nearest doctor or hospital in their personal vehicles? ____ YES ____ NO
Preferred Hospital for treatment: ____
If preferred Hospital isn't the closest facility is the nearest hospital ok? ____ YES ____ NO

Authorization for emergency medical care and transportation:

______________________________ ____ __________
Parent/Guardian Printed Name Signature Date

Field Trip & Transportation Permission

_____ I give the program permission to transport my child on field trips.
_____ I give the program permission to use in town transportation.
_____ I will provide the program with child's car seat and/or booster if needed.

Please read and initial below:

_____ I understand the programs hours and will be on time for drop off and pick up.
_____ I understand that if late for drop off my child's space may be forfeited and sold to another participant.
_____ I understand that if I pick up my child late, I will be charged $5 per additional minutes late.

_____ I have read and understand the programs policies and procedures.
_____ I □ **authorize** □ **do not authorize** the program to apply sunscreen on my child.
_____ If I do not authorize sunscreen, I will label sunscreen & give to staff for my child.

_____ I will provide the program with a copy of my child's immunization records before or on first day of camp.
_____ I will not send my child to this program if he/she is showing signs of illness or communicable disease.
_____ Please list the approximate dates your child has had the following:

________ Chicken Pox ________Rubella ________ Roueola ________ Fever ________ Asthma ________ Hay Fever
________ Diabetes ________ Mumps ________ Epilepsy ________ Whooping Cough ________ Poliomyelitis
________ Surgery ________ other
_____ I have given the program, in writing, all concerns or special challenges my child may have.

_____ My child is □ **authorized** □ **is not authorized** to sign him/herself out at the end of the day.
_____ I will allow my child to watch a video or movie rated: □ **G** □ **PG** □ **PG-13**

My signature below indicates I agree to all initialed items above.

______________________________ ____ __________
Parent/Guardian Printed Name Signature Date

The program has permission to take photographs, videos, digital images, and/or audio recordings while at camp.

Please circle one YES NO

______________________________ ____ __________
Parent/Guardian Printed Name Signature Date

If yes, please provide the phone number(s) you would like us to text photos and/or videos.

Phone: _________________________ Phone: _________________________ Phone: _________________________

Proof of Immunization Records

☐ I have attached my child's immunization records to this document.
☐ I do not have my child's immunization records & will email a copy or mail a copy to one of the below addresses within 30 days of today.

Email to: jodi@activitysitters.com or **Mail to:** Activity Camp PO Box 3938 Avon, Co 81620

______________________________ ____ __________
Parent/Guardian Printed Name Signature Date

*Please provide the records now or within 30 days of camp. We cannot readmit your child to camp until we have immunization records on-file.

Medication Administration Form

Only needed if your child has mandatory or emergency medication that must be administer during camp.

Activity Camp will **only administer emergency medications** unless advanced arrangements are made with the director.

Child's Full Name: ____ Date of birth: ____ /____ /____

EMERGENCY CONTACT INFORMATION

Parent/Guardian 1: ______________________________ Cell Ph: ______________ Work Ph: ______________

Parent/Guardian 2: ______________________________ Cell Ph: ______________ Work Ph: ______________

Child's Home Address: ____

****If on vacation, please use the address of your current accommodations****

EMERGENCY CONTACT INFORMATION

1: ______________________ Phone: ______________ 1: ______________________ Phone: ______________

Primary health care provider: ____ Phone: ______________

ALLERGIES - indicate **ALL** allergies including medications: Reaction symptoms:

______________________________________ ______________________________________

______________________________________ ______________________________________

SEVERE ALLERGY TO: ____

Child carries an Epi-Pen: Yes____ No____ If Yes, Epi-pen Junior____ or Epi-pen____ (66 lbs. & over)

Epi-pen treatment plan:

1. Epi-pen immediately administered when symptoms of severe allergic reaction occur.
2. 911 (or local emergency response team) called immediately or child transported to closest emergency medical facility immediately. Emergency medical services must always be called when Epi-pen is administered.
3. Parent/guardian or emergency contact person (if parent/guardian unavailable) contacted.
4. If parent/guardian or emergency contact is unavailable to accompany child to medical facility, camp staff will accompany the child and remain with the child until parent/guardian or emergency contact arrive at the facility.

FOOD ALLERGY

____ Family will provide child's snack
____ Camper will self monitor all food choices
____ Other ____

EMERGENCY MEDICATIONS PLAN - medication must be in original container clearly stating child's name, prescribing health care provider, medication name, dosage, and prescription date. Any medication that requires refrigeration or special storage conditions will not be permitted during camp.

Medical condition / reason: ______________________ Emergency medication: ______________________

Dose:__________ Time(s) given:__________ Instructions: ____

____

DAILY MEDICATIONS - Must include dosage details and time of day taken

Medication: ______________ Dose:________ Time(s) given: __________ Possible side effects __________

Medication: ______________ Dose:________ Time(s) given: __________ Possible side effects __________

It is understood by parents/guardians that this plan may be carried out by any Activity Camp staff member on duty.

Parent/Guardian Signature: ____ Date: ______ / _______ / _______
month day year

EMERGENCY TREATMENT PLAN - List any medical condition(s) requiring special treatment and your instructions

Condition: ______________________ Instructions: ____

____

Condition: ______________________ Instructions: ____

____

Additional Notes: