

Newton Parks and Recreation Summer Programs

Child's Name: _____

Camps Attending: _____

Please list all of the Newton Parks and Recreation Summer Programs your child will be attending so we can photocopy the paperwork for each program.

PAPERWORK NEEDED

Please email this paperwork to the camp your child is attending, or mail it to
Newton Parks and Recreation at 124 Vernon St, Newton, MA 02458

_____ Release Form

_____ Identification/Emergency Information (2 pages)

_____ Physical Form (2 pages) if your doctor's office has a standard medical examination print out for summer camps you may attach that in lieu of this form. **Examinations must be dated within 1 year of your child's participation at camp.** If your child has a summer physical scheduled, please submit your current physical until you receive the new form.

_____ Medication Forms (only if needed) if your child will be taking daily medications at camp, or if they will be bringing an inhaler or epi pen to camp, please make sure you fill out these forms. Newton Parks and Recreation Camp Health Supervisors are only allowed to administer oral medications.

All paperwork and balances must be submitted by May 15th. A \$25.00 late fee will be assessed for all late paperwork and payments.

You can pay your balance online with a Visa or Mastercard. To do this, go to www.activityreg.com and click on Massachusetts, then Newton Parks and Recreation. In the top right hand corner click on Login and you will be able to access your family account.

**Newton Parks and Recreation Department Summer Programs
Medical Release Form - 2015**

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child_____. However, if I cannot be reached, I hereby authorize the Summer Programs to transport my child to the Newton Wellesley Hospital, or _____ Hospital via Emergency Vehicle, and to secure for my child the necessary medical treatment. I understand that designated staff members at the Summer Programs are trained in the basics of First Aid and Cardio-Pulmonary Resuscitation, and I authorize them to administer immediate First Aid to my child when appropriate.

Signature of Parent(s)/Guardian(s) *Date*

Parental Consent Release From Liability and Indemnity For Participation In The Newton Parks And Recreation Department's Summer Programs

I/We, the undersigned parent(s) or guardian(s) of _____, a minor, do hereby consent to his/her participation in, and field trips with the Summer Programs. I/WE forever RELEASE, acquit, discharge and covenant to hold harmless the City of Newton, a municipal corporation of the Commonwealth of Massachusetts, and its successors, departments, officers, employees, servants and agents, of and from any and all actions, causes of actions, claims, demands, damages, costs, loss of services, expenses and compensation on account of, or in any way growing out of, directly or indirectly, all known and unknown personal injuries or property damages which I/WE may now or hereafter have as the parent(s) or guardian(s) of said minor, and also all claims or rights of actions or damages which said minor has or hereafter may acquire, either before or after his/her participation in, and field trips with, the Summer Programs. FURTHERMORE, I/WE hereby agree to protect the City of Newton and its successors, departments, officers, employees, servants and agents against any and all claims for damages, compensation or otherwise on the part of said minor growing out of or resulting from injury to said minor in connection with his/her participation in, and field trips with, the said Summer Programs and to INDEMNIFY, reimburse or make good to the City of Newton or its successors, departments, officers, employees, servants and agents any loss or damage or cost, including attorney's fees, the City of Newton or its representatives may have to pay if any litigations arise from said minor's participation in and field trips with, the said Summer Programs.

Signature of Parent(s)/Guardian(s) *Relationship* *Date*

Witness

THIS FORM MAY NOT BE ALTERED

Summer Programs - PHOTO RELEASE

I/WE, the parent(s) or guardian(s) of _____ do hereby grant permission for pictures to be taken of my child for the purpose of publicity for the Summer Programs. I understand that photo's may be published in local papers, on the website, or in future brochures for the Newton Parks and Recreation Department and the Summer Programs.

Signature of Parent(s)/Guardian(s) *Date*

**NEWTON PARKS AND RECREATION SUMMER PROGRAMS
IDENTIFICATION/EMERGENCY INFORMATION**

Child's Name _____ School _____ D.O. B _____
Address _____ City _____ Zip _____
Parent/Guardian _____ Phone _____
Employment _____ Hours _____ Phone _____
Parent/Guardian _____ Phone _____
Employment _____ Hours _____ Phone _____
Physician _____ Phone _____
Medical Insurance _____ Policy # _____

If parents can't be reached, call

Name _____ Phone _____ Relation _____
Name _____ Phone _____ Relation _____

IDENTIFYING INFORMATION

Eye Color _____ Hair Color _____ Gender _____
Height _____ Weight _____ Identifying Marks _____

HEALTH INFORMATION

Any serious illness or hospitalization _____
Medications currently taking _____
Please list any limitations, health concerns, etc _____
Allergies (asthma, medication, etc) _____
Reactions to above _____

PERSONS OTHER THAN PARENT/GUARDIAN AUTHORIZED TO PICK UP CHILD

Name _____ Phone _____ Relation _____
Name _____ Phone _____ Relation _____
Name _____ Phone _____ Relation _____

Parent/Guardian Signature _____ Date _____

IDENTIFICATION/EMERGENCY INFORMATION CONTINUED

HELP US GET TO KNOW YOUR CHILD BETTER

1. What are some of your child's likes and interests _____

Please attach a
photo of your
child here

2. Briefly describe your child's personality (quiet, outgoing, etc) _____

3. What are some things your child is looking forward to at camp? _____

4. Is there anything else that you want to share with us? _____

NEWTON PARKS AND RECREATION DEPARTMENT SUMMER PROGRAMS MEDICAL EXAMINATION

Please Note: Many doctor's offices have a standard medical examination print out for summer camps. These forms will be accepted in lieu of this medical examination from as long as they have all of the below information. Examinations must be dated within 1 year of your child's participation at camp.

Name _____ Birth Date _____

Age _____ Sex _____ Grade Entering _____ School _____

Parent/Guardian _____

Home Address _____

Home Phone _____ Work _____ Cell _____

Home Phone _____ Work _____ Cell _____

Emergency Contact _____ Relationship _____

Home Phone _____ Work _____ Cell _____

HEALTH HISTORY: To be filled out by a licensed physician. This examination should be performed within one year of the starting date of this program. Check if appropriate and give approximate dates.

ASTHMA _____ ATHLETES FOOT _____ CHICKEN POX _____

MUMPS _____ MEASLES _____ SINUSITIS _____

POLIO _____ FAINTING _____ CONSTIPATION _____

FREQUENT COLDS _____ EAR INFECTIONS _____ SORE THROATS _____

GLASSES _____ VISION PROBLEMS _____ HEAD LICE _____ WHOOPING COUGH _____

OPERATIONS _____ STOMACH TROUBLE _____

HEART TROUBLE _____

SEIZURES (type and frequency) _____

IMMUNIZATION HISTORY: This is a record of dates of basic immunizations and most recent booster doses. This must be completed in full prior to the start of the program.

DPT SERIES _____ / _____ / _____ DPT BOOSTER _____

TETANUS _____ TETANUS BOOSTER _____ / _____ / _____

POLIO/OPV SERIES _____ POLIO BOOSTER _____

MEASLES (2 live doses necessary after 12 months) _____ / _____

MUMPS _____ RUBELLA _____

MMR _____ MANTOUX TEST _____

HEPATITIS B _____ / _____ / _____

ALLERGIC REACTIONS:

BEE STINGS _____ PENICILLIN _____ OTHER _____

FOOD ALLERGIES _____

CURRENT MEDICATIONS _____

ANY RESTRICTIONS _____

The above information contained in the immunization and Health History is correct to the best of my knowledge. The person herein described is in good physical health and has my permission to engage in all prescribed program activities, except as noted above. This form must be signed by a Physician with respect to immunization history.

PHYSICIAN'S SIGNATURE

DATE

PHYSICIANS ADDRESS

PHYSICIAN'S PHONE NUMBER

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER

(To be completed by parent/guardian)

Name of Camper: _____ Age: _____ Parent/Guardian Name: _____

Food/Drug Allergies: _____ Diagnosis (at parents discretion): _____

Home Telephone: _____ Business/Cell Telephone: _____

Emergency Telephone: _____

Name of Licensed Prescriber: _____ Business Telephone: _____

Emergency Telephone: _____

Name of Medication: Dose given at camp: _____ Route of Administration: _____

Frequency: _____ Date Ordered: _____ Duration of Order: _____ Quantity Received: _____

Expiration date of Medications Received: _____ Special Storage Requirements: _____

Specific Directions (e.g., on empty stomach/with water): _____

Specific Precautions: _____

Possible Side Effects/Adverse Reactions: _____

Other medications (at parents' discretion): _____

Location where medication administration will occur: _____

(Over)

Authorization to Administer Medication to a Camper (page 2)

I hereby authorize _____ (NAME OF CAMP) _____ to administer, to my child, _____ (NAME OF CHIL(D)) _____ the medication(s) listed above, in accordance with 105 CMR 430.160.

105 CMR 430.160(A)

Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.

105 CMR 430.160(C)

Medication shall only be administered by the health supervisor* or by a licensed health care professional authorized to administer prescription medications. The health care consultant shall acknowledge in writing the list of medications administered at the camp. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.

105 CMR 430.160(D)

When no longer needed, medications shall be returned to a parent of guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

*Health Supervisor – A person who is at least 18 years of age, specially trained and certified in current American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.

Parent/Guardian Signature: _____ Date: _____

NEWTON PARKS AND RECREATION DEPARTMENT

Medication Form

I _____ the parent of _____

Do hereby give the Newton Parks and Recreation Department permission to administer the following prescribed medication(s) in the following prescribed dosage to my child when participating in the Newton Parks and Recreation Department Program.

MEDICATIONS MUST BE IN THE ORIGINAL CONTAINERS AND PACKED IN A ZIP LOCK BAG.

PLEASE PRINT OR TYPE:

Medications

Time

Dosage

Signature of Parent/Guardian _____

Date _____