

Brookfield Recreation Department
EMERGENCY CONTACTS & PICK UP AUTHORIZATION

Child's Name: _____ Camp Attending: _____

Household Information

Primary Guardian

Secondary Guardian

Name: _____

Name: _____

Date of Birth: _____

Date of Birth: _____

Daytime Phone: _____

Daytime Phone: _____

Cell Phone: _____

Cell Phone: _____

Email Address: _____

Email Address: _____

If the person(s) listed above cannot be reached in the case of an emergency, I authorize the following person to be contacted on my behalf:

Emergency Contact's Name: _____

Address: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

Pick up Authorization

The following person(s) have my permission to pick up my child from camp if I am ever unable to do so. Additional names/numbers can be added to the back of this form.

1. Name: _____ Relation to child: _____

Address: _____ Phone: _____

2. Name: _____ Relation to child: _____

Address: _____ Phone: _____

3. Name: _____ Relation to child: _____

Address: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

Permission to Walk and/or Ride a Bike to and from Camp (Kamp Kiwanis Only)

Child's Name: _____

____ My child, named above, has my permission to walk to and from Kamp Kiwanis each day.

____ My child, named above, has my permission to ride a bicycle to and from Kamp Kiwanis each day.

Parent/Guardian Signature: _____ **Date:** _____

Brookfield Recreation Department
CAMPER INFORMATION FORM

All information on this form will be kept confidential.

Child's Name: _____ Camp Attending: _____

What type of activities does your child enjoy participating in?

Does your child have any fears (water, insects, etc) that staff needs to be aware of?

Will your child require any special accommodations to participate in this program?

If Yes, please specify:

Are there any behaviors, physical or emotional concerns that staff should be aware of? If Yes, please specify:

Please use space below or on back of form to provide us with any additional information that would be helpful to staff to help us provide your child with a happy, healthy, safe summer day camp experience:

Brookfield Recreation Department
HEALTH AND MEDICAL HISTORY FORM

Child's Name: _____ Birthdate: _____

Address: _____ City: _____ Zipcode: _____

Will your child need to take any medications during the camp day? YES NO
If Yes, please fill out the enclosed Medication Form completely.

Does your child have any allergies? (insect stings, food, drugs, plants, etc) YES NO
If Yes, please list here:

Does your child have any chronic illnesses? (asthma, diabetes, nosebleeds, etc) YES NO
If Yes, please list here any information that would help staff care for your child:

Serious injury or operations that may limit your child's activity at camp? YES NO
If Yes, please list here any information that would help staff plan appropriate activities
for your child:

Specific activities to be encouraged: _____

Specific activities to be restricted: _____

Physician's Name: _____ Phone: _____

My child's physician is affiliated with the following hospital: _____

My child is covered by the following Health Insurance Plan:

Insurance Provider: _____ ID # _____

Brookfield Recreation Department
MEDICATION FORM

Strict policies have been put in place regarding the dispensing of medication to camp participants. These policies need to be followed if a participant is required to receive prescription medication and/or over the counter medications such as pain relievers, cough drops, etc. while participating in camp activities.

1. All medications are to be in the original containers, with original labels. For example: Milk of Magnesia tablets in a Milk of Magnesia box, labeled Milk of Magnesia.
2. All prescription medications must be in a pharmacy container properly labeled with prescription number, doctor's name, pharmacy address and phone number and medication name.
3. This "Medication Form" and the "Authorization and Indemnification For Administering Medication" must be filled out completely with all requested information for each medication your child is taking.

A COPY OF THIS FORM WILL BE GIVEN TO STAFF WITH THE MEDICATION. IF MORE THAN ONE TYPE OF MEDICATION IS TO BE TAKEN, PLEASE USE A SEPARATE FORM FOR EACH. MEDICATIONS ARE STORED IN THE FIRST AID KITS AT EACH CAMP SITE.

Name of child: _____

Name of medication: _____

Directions for taking medication: _____

Time medication should be taken: _____

Dosage of medication to be taken: _____

To help us provide a safe and healthy camp experience for your child, please state below any additional information needed as to medication's use, possible side effects, etc. whether the medication is prescribed or given as an over the counter remedy for allergies, illness, etc.: _____

VILLAGE OF BROOKFIELD
BROOKFIELD, IL 60513

RECREATION DEPARTMENT

AUTHORIZATION AND INDEMNIFICATION
FOR ADMINISTERING MEDICATION

Child's Name: _____ Birth Date: _____

Parent/Guardian Name: _____

Address: _____

Home Phone: _____ Day Time Phone: _____

Emergency Contact Name: _____ Phone: _____

To be filled out by physician:

Physician's Name: _____

Office Address: _____

Office Phone: _____ Emergency Phone: _____

Medication: _____

Dosage: _____ Frequency: _____

Time medication is to be administered or under what circumstances:

Prescription Date: _____ Order date: _____ Discontinuation Date: _____

Diagnosis requiring medication:

Must this medication be administered during the day in order to allow the child to attend camp or to address the child's medical condition? YES NO

Side Effects, if any: _____

Authorization and Indemnification

I, _____, hereby agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the Village of Brookfield, its employees, officials and agents, on my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the Village) lawfully prescribed medication. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a nurse, and specifically consent to such practices. I further agree to indemnify and hold harmless the Village of Brookfield, its employees, officials and agents against any claims arising out of the self-administration of medication by my child and any claims arising out of medications given by Village staff in my absence or in an emergency.

Parent/Guardian Name (printed): _____

Parent/Guardian Signature: _____

Date: _____