Financial Literacy Registration Form

Primary Parent/Guardian

First Name _____ Last Name _____ D.O.B. _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address_____

Secondary Parent/Guardian

First Name _____ Last Name_____ D.O.B. _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address_____

Participant First Name	Participant Last Name	D.O.B.	Gender	T-shirt Size

Does your child(ren) have allergies, special needs or take medication? ☐ Yes ☐ No *If yes, you must fill out the Medical Information Form and/or the Authorization for Administering Medication Form .*

Does your child currently have the following Immunizations? *If no to any, you must fill out the Medical Information Form.*

HBV	☐ Yes	☐ No	Tetanus	☐ Yes	☐ No
DTP	☐ Yes	☐ No	MMR	☐ Yes	☐ No
OPV	☐ Yes	☐ No	Varicella/Varivax	☐ Yes	☐ No

Permissions

I give the PABC permission to transport my child(ren), on field trips and in the case of an emergency. ☐ Yes ☐ No

I give permission and consent for my child(ren)'s photograph to be taken during camp session activities. I understand that any such photographs may be published and used by PABC to illustrate and promote Park Avenue Baptist Church and Youth Services and its programs. ☐ Yes ☐ No

I give my child(ren) permission to swim. ☐ Yes ☐ No
Each child will be tested for swimming to determine which pool areas they may enter. Please check the box that best reflects your child's ability:

☐ Unable to swim ☐ Able to swim, but not well ☐ Able to swim in all pool areas

Emergency Contacts and Pick Up /Drop Off Authorization

The following persons are to be contacted in the event of an emergency and if the parent or guardian cannot be reached. Proper photo identification is required for pick up.

Contact 1

Full Name _____ Relationship to Child _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Allowed to Pick up? ☐ Yes ☐ No If yes, provide driver's license number_____

Contact 2

Full Name _____ Relationship to Child _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Allowed to Pick up? ☐ Yes ☐ No If yes, provide driver's license number_____

Contact 3

Full Name _____ Relationship to Child _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Allowed to Pick up? ☐ Yes ☐ No If yes, provide driver's license number_____

Medical Contacts

Primary Care Physician_____ Phone _____

Primary Care Dentist _____ Phone _____

Preferred Hospital _____

In the event of an emergency, your child will be transported to the nearest hospital.

Participant Waiver

In consideration of your accepting my or my child's entry, I hereby, for myself, my child, my heirs, executors, and administrators, waive and release any and all rights and claims for damages I or my child may have against Park Avenue Baptist Church and Youth Services Department and its representatives, successors and assigns for any and all hurt, damage or loss sustained by myself or my child on any activity sponsored by these groups. I warrant that I have the right to authorize the foregoing uses and do hereby agree to hold Park Avenue Baptist Church and Youth Services Department harmless of and from any and all liability of whatever nature which may arise out of result from such uses. For the consideration stated above, I further agree that in the event that my child repudiates or attempts to repudiate such release, I will personally indemnify and save harmless Park Avenue Baptist Church and Youth Services Department, its successors and assigns, for any and all loss and damage occasioned thereby.

Furthermore, I certify that the above submitted information contained in this document is true and accurate.

Parent/Guardian Signature _____

Medical Information Form

Please fill out one form per child.

If your child takes medication, you must fill out the Medication Administration Form.

Participant Name_____

Participant Allergies and Intolerances

Please list all allergies and/or intolerances.

_____

_____

_____

Participant Special Needs or Medical Disabilities

Please list any special needs or medical disabilities that our staff should be aware of in order to best serve your child. Should a participant be unable to cope with the rigorous activity schedules, it may be necessary for a family member or aide to remain with your child. This should be discussed with the facility supervisor before the participant begins the program.

_____

_____

Waiver for Non-Immunized Child

The above named participant has not received the required immunizations against the specific disease(s) listed below.

☐ HBV ☐ Tetanus

☐ DTP ☐ MMR

☐ OPV ☐ Varicella/Varivax

If your child has not been immunized for medical reasons, please list condition(s) and have physician sign below.

_____

Physician Signature_____ Date_____

I understand that in the event of an outbreak of any disease checked above, my child will be subject to exclusion from class for the duration of the outbreak, which would be until at least two weeks after the last reported case, unless I provide a statement signed by the physician who saw and diagnosed my child as having had the disease in question. (A physician diagnosed history of disease is accepted for measles and mumps only. A positive laboratory test is the only acceptable proof of having had rubella.) Should a child be asked to leave class due to an outbreak of any disease, they would not be eligible for a refund of any portion of their class fees.

Parent/Guardian Signature_____ Date_____

Authorization for Administering Medication

Please fill out one form per child.

PABC discourages the use of medications during program hours. ***If possible, please have your child take medications before or after program hours.***

Child's Name: _____

Check One:

☐ Authorization for antibiotic (10 days or less)

☐ Authorization for over-the-counter medication (3 days or less)

☐ Authorization for Epinephrine, Inhalers & other prescribed medications (**Requires Physician's Signature**)

Diagnosis: _____

Name of Medication: _____

Date of First Dosage: _____ Effective from _____ to _____

Dosage amount to administer during program hours: _____

Date(s) and times to administer: _____

Side Effects: _____

If the child will be taking more than one medication at a time, list the sequence in which medications should be administered: _____

Check as appropriate ***(**medication expiration date must be clearly indicated)***

Ana-Kit

☐ Give pre-measured dose of .3mg of Epinephrine 1:1000 aqueous solution. (0.33cc)

☐ Repeat dose in 15 minutes if rescue squad has not arrived. (2 kits will be needed)

Epi-pen, Jr.

☐ Give pre-measured dose of 0.15 mg or Epinephrine 1:2000 aqueous solution . (0.3cc)

☐ Repeat dose in 15 minutes if rescue squad has not arrived. (2 kits will be needed)

Epi-pen

☐ Give pre-measured dose of 0.3mg of Epinephrine 1:1000 aqueous solution. (0.3cc)

☐ Repeat dose in 15 minutes if rescue squad has not arrived. (2 kits will be needed)

I acknowledge that this child has received adequate information on how and when to use Ana-Kit or Epi-pen and that the child can properly use it in an emergency. Parent/Guardian initial here _____

I hereby authorize PABC staff to facilitate the use of medications by my child, including the injection(s) of Epinephrine as stated in this authorization. I agree to release, indemnify, and hold harmless PABC, its personnel and/or agents from lawsuit, claims, expense, demand or action against them for assisting my child with medication use/ administration, provided the staff complies with the authorized orders established above. I have read the Medication Administration Procedures and I assume responsibilities as required.

Parent/Guardian Signature _____ Date _____

The information above is accurate. Medication administration arrangements before and after program hours are not possible.

Physician's Name (print) _____ Phone_____

Physician's Signature _____ Date_____

Medication Administration Procedures

1. Personnel may not accept medications unless the Authorization for Administering Medication Form is completed and signed.
2. All medication is kept in a locked area, only accessible to authorized personnel.
3. Under no circumstances may any staff member facilitate the taking of any medications outside the procedures outlined in the Medication Administration Procedures.
4. PABC does not assume responsibility for unauthorized medication taken independently by the child.
5. Medications should be administered at home whenever possible. The first dosage of any medication must be taken at home, if necessary for early control/treatment of the child's medical condition. All medications to be administered during program hours must have parent/guardian authorization. Some medications also require authorization by a physician. The parent/guardian must transport the medication to the appropriate camp drop-off area or extended care area, and give to designated staff.
6. The medication must be properly labeled with the child's name, medication name, exact dosage to be taken, exact time dose is to be taken and the expiration date. The medication must be in the original container. The form and container must match.
7. If the medication is in pill form, the number of pills in the container has to correspond with the number of days and times the child will attend the program. If repeat doses of Epi-pen are in the physician's order, two Epi-pen kits must be supplied.
8. Medications other than liquid/pill, Epi-pen, ear/eye drops, and inhalers will be handled on a case-by-case basis. Please contact the facility supervisor for assistance.
9. A physician may use office stationery or prescription pad in lieu of completing Authorization for Administering Medication Form. Required information includes: child's name, date of birth, duration, diagnosis, medication name, dosage, time to take medication, and sequence if more than one is to be taken, side effects and physician's signature and date.
10. The parent/guardian is responsible for submitting a new form each time there is a change in medication, dosage and/or a change in conditions under which medication is to be administered.
11. The parent/guardian must pick up unused portions of medication immediately after the effective date expires or at the end of the child's enrollment. Medications not claimed will be destroyed.