Please return prior to your child's first day of camp.

Indy Parks and Recreation Summer Day Camps
Emergency Form 2024
Drop off at a **Day Camp Location** or mail to
INDY PARKS and RECREATION, Customer Service, Summer Day Camps
1720 Burdsal Parkway, Indianapolis, IN 46208

Camper Information Section: (Please Print Clearly)

Camper's Name: _____ Nick Name:_____

Birth Date:_____ Age:_____(during camp)

Address:_____ City:_____ State:_____ Zip:_____

Home Phone Number:_____ Day Camp Location**:** _____

School Attending in Fall: _____ Grade to attend in Fall:_____

Parent/Guardian & Emergency Information Section:

Parent/Guardian's Name:_____Relationship:_____

Address If Different:_____ City:_____ State:_____ Zip:_____

Day Phone Number: (___)_____ Evening Phone Number: (___)_____

Work Phone Number: (___)_____ Cell Phone Number: (___)_____

Email: _____

Parent/Guardian's Name:_____Relationship:_____

Address If Different:_____ City:_____ State:_____ Zip:_____

Day Phone Number: (___)_____ Evening Phone Number: (___)_____

Work Phone Number: (___)_____ Cell Phone Number: (___)_____

Email: _____

Additional Emergency Contact:

Contact Name:_____Relationship:_____

Phone Number:(__)_____Phone Number:(___)_____Phone Number:(___)_____

Authorization for Pick-Up: **(MUST BE FILLED OUT)**
Person's authorized to pick up camper: **(other than parent/guardian listed above)**

1. Name:_____Cell Number:_____ Work Number:_____

2. Name:_____Cell Number:_____ Work Number:_____

3. Name:_____Cell Number:_____ Work Number:_____

4. Name:_____Cell Number:_____ Work Number:_____

Person's NOT authorized to pick up camper.

1._____ 2._____ 3._____

Health History and Authorization for Treatment:

(***All Questions Must be Marked***)

In the past year….

1. Has this camper required any counseling or hospitalization? **Yes or No** Explain_____

_____

2. Has this camper had any operations or serious injuries? **Yes or No** Explain_____

_____

Does this Camper…

3. Have an emotional, intellectual and/or physical disability? **Yes or No** Explain_____

_____

4. Have an Individualized Education Plan (IEP) that you would be willing to share? **Yes or No**

_____

5. Have activity encouraged or limited by a physician? **Yes or No** Explain_____

_____

6. Have dietary modifications due to medical or religious guidelines? **Yes or No** Explain_____

_____

7. Use assistive devices? Glasses, Hearing, Leg Braces**…** **Yes or No** Explain_____

_____

8. Use an Epi-Pen? **Yes or No** Will you be sending an Epi Pen with your camper? **Yes or No**

_____

9. Other? Parent/Guardian concerns? Phobias, Allergies…**Yes or No**

Explain_____

Physician's Name: _____ Office Phone Number: ( )_____

Immunizations

My child's immunizations are up to date as required by Indiana Public Schools. **Yes or No**

If your child is not up to date as required by Indiana Public Schools please list the dates below or attach immunization record:

Month/Year

Vaccine	**Month/Year**	**Vaccine**	**Month/Year**	**Vaccine**	**Month/Year**
DTP	_____	Influenza B	_____	MMR	_____
Polio	_____	Hepatitis B	_____	Or Measles	_____
Varicella (chicken pox)	_____			Or Mumps	_____
				Or Rubella	_____

Tetanus Shot
All campers must list date of last Tetanus. _____
month/year

Authorization for Treatment:

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. I hereby give permission to the medical personnel selected by the Indy Parks and Recreation SDC and/or Park Manager to order X-rays, routine tests, treatment, and necessary transportation for the person herein described. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Indy Parks and Recreation SDC and/or Park Manager to secure and administer treatment, including hospitalization, for the person named above. The complete forms may be photocopied for trips off site.

(Parent Initials)_____

SIGNATURE OF PARENT OR GUARDIAN

X_____ **Date:**_____

Requested Place for Treatment: (Hospital Name) _____

Authorization to Administer Medication:

Although we encourage medication to be given to your child before or after camp, we understand there might be a need for your child to receive medication during camp hours. A procedure has been established for medications to be administered by camp staff. **Medications** must be brought to camp in the original **containers** with clearly written directions for usage. I hereby give my consent for the staff to administer medication(s) to: (Camper's name) _____as prescribed according to the below instructions. **(Parent Initials)**_____

MEDICATIONS: (**Please send all medications in original RX bottles with directions**)

Med. #1_____ M T W Th F **Med. #2**_____ M T W Th F

Med. #3_____ M T W Th F **Med. #4**_____ M T W Th F

Photographic Release

I hereby **(DO)** or **(DO NOT)** (circle one) grant to The Consolidated City of Indianapolis (City), its representatives and employees the right to take photographs of me, minor children, children under my guardianship, and my property brought onto City properties in connection with activities occurring at and in conjunction with Indy Parks and Recreation. I authorize City, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that City may use such photographs of me, minor children, children under my guardianship, and my property with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

SIGNATURE OF PARENT OR GUARDIAN

X_____ **Date:**_____

Participant Demographics

Dear Indy Parks and Recreation Program Participant:

Indy Parks and Recreation receives funding from different city, state, federal and private agencies that require us to report demographic information on the users of our programs and services. Please complete the following information down below and return it to the program area manager or coordinator.

This information is kept confidential.

Participant Initials:_____ **Program Coordinator Initials:_____**

Program Location:_____

Parent/Guardian Information

X	**Marital Status**
	Single
	Married

X	**Employment**
	Employed for wages
	Unemployed
	Student
	Stay at Home Parent

X	**Education**
	Student
	High School Graduate
	Technical School Graduate
	College Graduate

X	**Family Income Level**
	Below $9,999
	$10,000-$14,999
	$15,000-$19,999
	$20,000-$29,999
	$30,000-$39,999
	$40,000-$49,999
	$50,000-$59,000
	Over $60,000

Child's Information

X	**Racial Background**
	American Indian
	Asian
	Black/African American
	White/Caucasian
	Multi Racial
	Other

X	**Ethnicity**
	Hispanic or Latinx
	Not Hispanic or Latinx

X	**Age**
	3-5 years
	6-8 years
	9-11 years
	12-15 years
	16-18 years
	19+ years

X	**Gender**
	Male
	Female
	Prefer to Self Describe as_____
	Prefer not to Say

X	**Disabilities**
	Physical
	Intellectual
	Emotional
	Combination