

**CITY OF BALDWIN PARK
DEPARTMENT OF RECREATION & COMMUNITY SERVICES**

**BEFORE & AFTER SCHOOL CARE and DAY CAMP
REGISTRATION & EMERGENCY FORM**

CHILD'S NAME LAST:		FIRST:	M.I.:	HOME PHONE:
ADDRESS:		CITY:	ZIP:	
AGE:	BIRTHDAY:	GRADE:	RM#:	TEACHER:
FATHER'S NAME:			Cell:	
EMAIL:				
ADDRESS (IF DIFFERENT FROM ABOVE):		CITY:	ZIP:	WORK PHONE:
MOTHER'S NAME:			Cell:	
EMAIL:				
ADDRESS (IF DIFFERENT FROM ABOVE):		CITY:	ZIP:	WORK PHONE:
PERSON RESPONSIBLE FOR CHILD:				

PERSONS ALLOWED TO BE CALLED IN AN EMERGENCY AND AUTHORIZED TO TAKE CHILD FROM FACILITY (CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR GUARDIAN)		
NAME	RELATIONSHIP	TELEPHONE

I, _____ CERTIFY THAT MY CHILD _____ IS IN GOOD HEALTH, HAS NO PHYSICAL DISABILITIES OTHER IMPEDIMENTS WHICH WOULD ENDANGER MY CHILD WHILE PARTICIPATING IN THE ABOVE MENTIONED PROGRAM. I, HEREBY, GIVE CONSENT TO MY CHILD'S PARTICIPATION THEREIN.

A MINOR CANNOT RECEIVE MEDICAL TREATMENT WITHOUT PARENTAL PERMISSION, THIS CREATES DIFFICULTIES IN EMERGENCY SITUATIONS. BY SIGNING THE FOLLOWING FORM, YOUR CHILD COULD RECEIVE MEDICAL ATTENTION IMMEDIATELY IN THE EVENT OF AN ACCIDENT, WITHOUT OBTAINING PERMISSION AGAIN FROM YOU AT THE TIME OF THE EMERGENCY, OF COURSE, EVERY ATTEMPT WOULD BE MADE TO NOTIFY YOU AS SOON AS POSSIBLE. THEREFORE, SHOULD WE BE UNABLE TO REACH YOU OR ANOTHER DESIGNATED PERSON, YOUR CHILD WILL RECEIVE IMMEDIATE CARE.

IN CASE OF MEDICAL EMERGENCY, I UNDERSTAND EVERY EFFORT WILL BE MADE TO CONTACT PARENTS OR GUARDIANS OF STUDENTS. IN THE EVENT I CANNOT BE REACHED I, HEREBY, GIVE MY PERMISSION TO THE PHYSICIAN SELECTED BY THE TEACHER TO HOSPITALIZE, SECURE PROPER TREATMENT FOR, AND TO ORDER INJECTION, ANESTHESIA, OR SURGERY FOR MY CHILD NAMED ABOVE. I ALSO AGREE THAT THE SCHOOL NURSES OR PARAMEDIC CAN ADMINISTER NON-PRESCRIPTION MEDICATION, IF NECESSARY.

SIGNATURE

DATE

OFFICE USE ONLY DAY				
BASIC SCHOOL SITES:	FOSTER	GEDDES	KENMORE	
	TRACY	VINELAND	WALNUT	
DAY CAMP:	THANKSGIVING	WINTER	SPRING	SUMMER

**CITY OF BALDWIN PARK
DEPARTMENT OF RECREATION & COMMUNITY SERVICES**

**BEFORE & AFTER SCHOOL CARE (BASiC) and DAY CAMP PROGRAMS
HEALTH QUESTIONNAIRE**

(PLEASE PRINT)

NAME OF
CHILD:

LAST

FIRST

M.I.

SEX: Male Female

AGE: _____

D.O.B: ____/____/____

PHONE: () _____

ADDRESS: _____

CITY: _____ ZIP: _____

PARENT/GUARDIAN: _____

1. HAS YOUR CHILD HAD A RECENT CHECK-UP WITH YOUR FAMILY HEALTH ADVISOR? YES NO

2. DATE OF THE MOST RECENT PHYSICAL EXAMINATION? _____

3. DOES YOUR CHILD HAVE A HEALTH PROBLEM? YES NO IF YES, PLEASE EXPLAIN: _____

4. HAS YOUR CHILD HAD A SERIOUS ILLNESS, OPERATION OR PROBLEM? YES NO

5. DOES YOUR CHILD HAVE ANY DISABILITIES OR CHRONIC RECURRING ILLNESSES? YES NO

IF YES, PLEASE EXPLAIN: _____

6. IS YOUR CHILD ALLERGIC OR SUBJECT TO ANY OF THE FOLLOWING?

FOODS _____
 ANTIBIOTICS _____
 OTHER _____

FAINTING SPELLS
 INSECT BITES
 EAR INFECTIONS
 POISON OAK

7. WHILE ATTENDING DAY CARE/DAY CAMP, WILL YOUR CHILD HAVE ANY SPECIAL NEEDS? YES NO IF YES, PLEASE

EXPLAIN: _____

8. IF ANY, WHICH ACTIVITIES AT BASiC/DAY CAMP ARE RESTRICTED FOR YOUR CHILD? _____

9. HEALTH HISTORY (CHECK AS MANY AS NECESSARY)

HEART DEFECTS
 CONVULSIONS
 DIABETES
 HAY FEVER

ASTHMA
 BLEEDING
 MEASLES
 CHICKEN POX

MUMPS
 MONONUCLEOSIS
 GERMAN MEASLES
 OTHER _____

DATES

EMERGENCY TREATMENT

NAME OF DOCTOR: _____ PHONE #: () _____

TYPE OF INSURANCE: _____ POLICY #: _____

PLEASE LIST BELOW ANY HEALTH CONDITION THAT MIGHT AFFECT YOUR CHILD'S PARTICIPATION IN OUR DAY CARE/DAY CAMP.