Victor Parks & Recreation
Recreational Afterschool Program
2017-2018
Registration Form

Child's Name ____ Age ____________

School ____ Grade __________

Birthdate _____/_____/_________

Parent/Guardian Names ____

Address ____ Zip Code _________

Primary Phone ____________________ Secondary Phone ______________________

Work Phone ______________________

Email Address ____

Emergency Contact ______________________________________ Phone __________

Doctor's Name ____ Phone __________

Dentist's Name ____ Phone __________

Additional Information ____

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AGREEMENTS:

No refunds will be given except when the child moves from the area or a doctor certifies illness of the participant. A $10.00 administrative fee will be withheld on all refunds unless the program is cancelled.

In case of accident or injury, I authorize any and all emergency medical, dental and/or surgical care and hospitalization advised by the physicians, surgeon or hospital necessary for the proper health and wellbeing of any child.

I HEREBY UNCONDITIONALLY RELEASE THE Town of Victor Parks and Recreation Department from any and all responsibility or liability for any injuries which may be sustained by me or my minor child(ren) in relation to participation in any of the Victor Parks and Recreation programs or activities with the Parks and Recreation Department. I acknowledge that neither I nor my child(ren) suffer from any physical impairments and have no limitations upon engaging in activities with the Parks and Recreation Department. I unconditionally release the Town of Victor and its agents or employees from any and all liability for injuries and understand and acknowledge that the Town of Victor Parks and Recreation Department carries no liability or accident insurance. In the event that my child(ren) is injured, I authorize the party or person in charge of my child(ren)'s activities to seek medical care. I acknowledge and understand that I will be solely responsible to pay the cost of such care. And I further release and hold harmless the Town of Victor and its Parks and Recreation Department for any medical arrangements or care provided me or my minor child(ren).

SIGNATURE REQUIRED:____**DATE:**__________
SIGNATURE OF ADULT PARTICIPANT, PARENT OR GUARDIAN

☐ Please check this box if you DO NOT want your or your child's photo to be used

Victor Parks & Recreation
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Emergency Contact Form

Please complete the following information before your child participates in this program. In addition, please send us a note if anyone other than those indicated below will be picking up your child. Prompt pick-up is expected. Please sign your child out when picking them up.

Child's Name ____ Phone ______________________

Parent Name ____ Day Phone _________________

Parent Name ____ Day Phone _________________

Others who may be contacted in case of emergency:

Name (relationship) ____ Day Phone _________________

Name (relationship) ____ Day Phone _________________

Name (relationship) ____ Day Phone _________________

Others who are authorized to pick up your child:

Name (relationship) ____ Day Phone _________________

Name (relationship) ____ Day Phone _________________

Name (relationship) ____ Day Phone _________________

Please share with us any medical concerns or medical information about your child:

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If you have a child with special needs, please complete the attached Individual Health Care Plan so we can better serve your child.

Parent/Guardian Signature ____________________________________ Date _____________________

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

You may use this form or an approved equivalent to document an individual health care plan developed for a child with special health care needs.

A child with a special health care need means a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.

Working in collaboration with the child's parent and child's health care provider, the program has developed the following health care plan to meet the individual needs of:

Child Name:	Child date of birth:
Name of the child's health care provider:	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner

Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.

Identify the caregiver(s) who will provide care to this child with special health care needs:

Caregiver's Name	Credentials or Professional License Information (if applicable)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Describe any additional training, procedures or competencies the caregiver identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

This plan was developed in close collaboration with the child's parent and the child's health care provider. The caregivers identified to provide all treatments and administer medication to the child listed in the specialized individual health care plan are familiar with the child care regulations and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Program Name:	License/Registration Number:	Program Telephone Number:
Child care provider's name (please print):		Date:
Child care provider's signature: **X**		

Signature of Parent:

X	Date: