

2011 SUMMER DAY CAMP REGISTRATION FORM

If registering more than one participant, please complete an additional form. Return, fax or mail to NWSRA, 3000 Central Road, Suite #205, Rolling Meadows, IL 60008. Fax to 847/392-2870. Questions? Call - Voice: 847/392-2848. Would you like to be added to our mailing list, please check.

NWSRA regards and treats personal information about participants as confidential, except in certain unusual situations in which NWSRA may have a duty to provide such information to third parties in order to avoid unreasonable risks of harm to them or to other individuals in their care. THE FOLLOWING INFORMATION MUST BE COMPLETED IN FULL AND VERIFIED BY A SIGNATURE BEFORE THE PARTICIPANT IS ALLOWED TO JOIN ANY NWSRA PROGRAM.

REGISTRATION DEADLINE: Monday, April 25

Contact Information:

Participant's Name (Last) _____ (First) _____

Address _____ City _____ Zip _____

Home Ph. # (____) _____ Sex: F ____ M ____ Age ____ Birthdate _____

School _____ Spec. Ed. Classification/Medical Diagnosis _____

School Address _____ City _____ Zip _____ Teacher _____

School District _____ Park District _____ Township _____

Parent/Guardian Information: Mother's Name (Last) _____ (First) _____

Father's Name (Last) _____ (First) _____

Mother's e-mail: _____ Father's e-mail: _____

Address (if different from above) _____ City _____ Zip _____

Home Ph.# (M)(____) _____ (F)(____) _____ Work Ph.# (M)(____) _____ (F)(____) _____

Mother's cell: _____ Father's cell: _____

Alternate Emergency Contact _____ Relationship to Participant _____

Home Ph. # (____) _____ Work Ph. # (____) _____

First & last names of people authorized to pick up participant _____

A. SEIZURES: Yes ____ No ____ Are seizures controlled by medication? Yes ____ No ____ Date of last seizure: _____

Please describe type of seizure and treatment desired: _____

B. MEDICAL CONDITIONS/NEEDS: Diabetes ____ Shunts ____ Braces ____ Canes ____ Walker ____ Glasses ____ PKU ____ G-tube ____

Trach ____ Epi-pen ____ Sign Language Assistance ____ Hearing Aid ____ Wheelchair (type) _____ (size) _____

C. Does participant require assistance for personal care (toileting, transferring, feeding, changing)? Yes ____ No ____ (If yes, a personal care information form will be sent to you.)

D. If using a wheelchair is participant capable of transferring? Yes ____ No ____

E. AAI Condition: If a participant has Down Syndrome, have x-rays of the C-1 and C-2 vertebrae been taken and examined? Yes ____ No ____

Date _____ Is participant clear of Atlantoaxial Instability Condition (AAI)? Yes ____ No ____

F. Allergies (specific) _____ Other _____

List specific medical instructions: _____

G. T-shirt size: CHILD SIZES: S(6-8) M(10-12) L(14-16) ADULT SIZES: S(34-36) M(38-40) L(42-44) XL(46-48)

H. SWIM INFORMATION: Pre-beginner ____ Beginner ____ Intermediate ____ Advanced ____

Permission for your child to use the diving board: Yes ____ No ____

I. Does your child wear a harness for transportation? Yes ____ No ____ SIZE: Small ____ Medium ____ Large ____

J. Is a bus aid required? Yes ____ No ____ Why? _____

K. Parents are asked to provide bug spray and sunscreen. Permission for staff to apply these products on your child. Yes ____ No ____

L. PHOTO PERMISSION: Photo permission for NWSRA publicity purposes. Yes ____ No ____

M. TEACHER INPUT: We would like your permission to contact your child's teacher for input on motor skills, activity preferences and socialization. Yes ____ No ____

Please fill out the following questions thoroughly so that we can best serve your child.

1. My child's favorite activities are: _____

2. My child should not eat: _____

3. Inappropriate activities: _____

4. Areas/Goals for the counselor to work toward: _____

5. Socialization skills: _____

6. Does your child exhibit any extreme behaviors or personality traits of which we should be made aware? _____

7. Toilet training: _____

(Over)

*District 54 school nurse will dispense medications. Please inform us of any medications needed so arrangements can be made with the nurse. For participants not needing medication dispensed at programs but would like to make us aware, please list all medications.

MEDICATION:	TYPE	DOSAGE	TIME

Doctor's Name _____ Phone (_____) _____

CHECK CAMP(S)	CAMP #	CAMP OPTIONS	CIRCLE IF MED. IS NEEDED AT CAMP		FEE
	4165	<i>District 15 Day Camp (Mon. - Thurs. only)</i>	Yes	No	\$229.50
	4165 & 4174	<i>District 15 Day Camp & After Care (Mon. - Thurs. only)</i>	Yes	No	\$409.50
	4172	<i>ALL INCLUSIVE (Day Camp, After Care & Special Events)</i>	Yes	No	\$559.50
	4072	<i>Summers End Adventures (without bussing)</i>	Yes	No	\$106.25
	4072	<i>Summers End Adventures (with bussing)</i>	Yes	No	\$181.25
	7250	<i>Summertime Fun Special Event (July 1)</i>	Yes	No	\$30.00
	7260	<i>Summertime Fun Special Event (July 8)</i>	Yes	No	\$30.00
	7270	<i>Summertime Fun Special Event (July 5)</i>	Yes	No	\$30.00
	7280	<i>Summertime Fun Special Event (July 22)</i>	Yes	No	\$30.00
	7290	<i>Summertime Fun Special Event (July 29)</i>	Yes	No	\$30.00

If requesting divided payments, please check Subtotal _____

A third of the total fee is due by May 2, May 16 and May 30. (-\$20 if sibling discount) _____

You may charge your registration. Please check one.

American Express Discover

MasterCard Visa

Account # _____

Exp. Date ____ / ____

(past program credits if applicable) _____

Total Cost _____

Make check payable to NWSRA

TOTAL AMOUNT ENCLOSED _____ (minimum deposit of \$50.00 per camp, per child required)

Safety

NWSRA is committed to conducting programs with the utmost safety and concern for participants. Those registering for programs must recognize, however, that there are potential risks of injury when participating in recreation programs. NWSRA continually strives to reduce such risks and provides safety rules and instructions to protect participants.

Insurance

NWSRA carries liability insurance only. The cost of medical insurance coverage for injuries would make program fees prohibitive, therefore it is the responsibility of each individual or family to provide their own medical insurance. NWSRA must have the following information, however, in case of an emergency.

Medical Insurance Company _____ Policy # _____

NWSRA Waiver and Release of All Claims

The NWSRA is committed to conducting its recreation programs and activities in a safe manner and holds the safety of participants in high regard. The NWSRA continually strives to reduce such risks and insists that all participants follow safety rules and instructions that are designed to protect the participants' safety. However, participants and parents/guardians of minors registering for the programs/activities listed above must recognize that there is an inherent risk of injury when choosing to participate in recreational programs/activities. You are solely responsible for determining if you or your minors child/ward are physically fit and/or skilled for the activities contemplated by this agreement. It is always advisable, especially if the participant is pregnant, disabled in any way or recently suffered an illness, injury or impairment, to consult a physician before undertaking any physical activity. Recreational programs/activities are intended to challenge and engage the physical, mental and emotional resources of each participant. Despite careful and proper preparation, instruction, medical advice, conditioning and equipment, there is still a risk of serious injury when participating in any recreational program/activity. Understandably, not all hazards and dangers can be foreseen. Depending on the particular activity, participants must understand that certain risks, dangers and injuries due to inclement weather, slipping, falling, poor skill level or conditioning, carelessness, horseplay, unsportsmanlike conduct, premises defects, inadequate or defective equipment, inadequate supervision, instruction or officiating, and all other circumstances inherent to indoor and outdoor recreational activities/programs exist. In this regard, it must be recognized that it is impossible for the NWSRA to guarantee absolute safety. Please read this form carefully and be aware that in signing up and participating in the above identified programs/activities, you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages or loss which you or your child/ward might sustain as a result of participating in any and all activities connected with and associated with said programs/activities (including transportation services/vehicle operation, when provided.).

I recognize and acknowledge that there are certain risks of physical injury to participants in these programs/activities, and I voluntarily agree to assume the full risk of any and all injuries, damages or loss, regardless of severity, that my minor child/ward or I may sustain as a result of said participation. I further agree to waive and relinquish all claims I or my minor child/ward may have (or accrue to me or my child/ward) as a result of participating in these programs/activities against the NWSRA including its officials, agents, volunteers and employees (hereinafter collectively referred as NWSRA). I do hereby fully release and forever discharge the NWSRA from any and all claims for injuries, damages, or loss that my minor child/ward or I may have or which may accrue to me or my minor child/ward and arising out of, connected with, or in any way associated with these programs/activities. I have read and fully understand the above important information, warning of risk, assumption of risk and waiver and release of all claims. If registering on-line or via fax, your online or facsimile signature shall substitute for and have the same legal effect as an original form signature.

Signature _____ Date _____

Please Print Name _____

SEIZURE INFORMATION SUMMER 2011

IF YOUR CHILD HAS SEIZURES, this form MUST be completed and verified by a signature before the participant is allowed to join any NWSRA program. Please check the correct response, complete each category and list any other information you feel NWSRA should be aware of to provide safe and enjoyable activities for the individual being registered

CONTACT INFORMATION:

Participant's Name: _____ Date of Birth: _____
 Parent/Guardian Name: _____ Tel.(H) _____ (W) _____ (C) _____
 Other Emergency Contact: _____ Tel.(H) _____ (W) _____ (C) _____
 Participant's Primary Care Dr.: _____ Tel: _____

SEIZURE INFORMATION:

1. When was the participant diagnosed with seizures or epilepsy? _____

Seizure Type	Length	Frequency	Description
Absence (staring spell)			
Simple Partial			
Complex Partial			
Atonic (drop)			
Generalized (Gran Mal)			
Other (explain):			

2. What might trigger a seizure in the participant? _____
 3. Are there any warnings and or behavior changes before the seizure occurs? Yes ___ No ___ If yes, please explain: _____
 4. When was the participant's last seizure? _____
 5. Has there been any recent change in the participant's seizure patterns? Yes ___ No ___ If yes, please explain: _____
 6. How does the participant react after a seizure is over? _____
 7. How do other illnesses affect the participant's seizure control? _____

BASIC FIRST AID: Care and Comfort Measures

8. What basic first aid procedures should be taken when the participant has a seizure? _____

SEIZURE EMERGENCIES:

9. Please describe what constitutes an emergency for the participant? _____
 10. Has the participant ever been hospitalized for continuous seizures? Yes ___ No ___ If yes, please explain: _____

A seizure is generally considered an emergency when: A convulsive (tonic-clonic) seizure lasts longer than 5 minutes • Repeated seizures without regaining consciousness • A first time seizure • Participant is injured or diabetic • Participant has breathing difficulties • Participant has a seizure in water.

SEIZURE MEDICATION AND TREATMENT INFORMATION:

11. What medication(s) for seizures does the participant take?

Medication	Date Started	Dosage	Frequency and time of day taken	Possible side effects

12. What emergency/rescue seizure medications are prescribed for the participant?

Medication	Dosage	Administration Instructions (timing* & method**)	What to do after administration:

*After 2nd or 3rd seizure, for cluster of seizure, etc. **Orally, under tongue, rectally, etc. NWSRA DOES NOT ADMINISTER RECTAL VALIUM.

13. Does your child have a Vagal Nerve Stimulator Yes ___ No ___ If yes, please describe instructions for appropriate magnet use: _____

GENERAL COMMUNICATION ISSUES:

14. What is the best way for us to communicate with you about the participant's seizure(s)? _____
 15. Is there any other information that NWSRA should know? _____

Parent/Guardian Signature: _____ Date: _____
 Dates Updated: _____, _____