

Camp DaVinci/Leonardo Child Information - 2011

Please turn in this completed form on the first day at the check-in area.



Program Rules

1. I will only leave the program with an adult that I know.
2. I will respect fellow children and instructors.
3. I will participate in all of the activities to the best of my ability.
4. I will act in a safe and responsible manner.
5. I will have fun!

I have read the Camp DaVinci rules, and I will abide by these rules. I understand that the Camp DaVinci staff has the right to remove any person from the program that does not abide by these rules. If I am asked to leave, I understand that my tuition is nonrefundable.

Child's Name Date of Birth

City and State of School Grade Level Next Fall

Parent/Guardian Name

Street Address

City, State and Zip Code

Parent/Guardian **Home** Phone Number

Parent/Guardian **Work** Phone Number

Parent/Guardian **Cell** Phone Number

Child Signature Date

Parent/Guardian Signature Date

Alternate Contacts/Transportation Arrangements

I authorize the following individual(s) to pick up my child from the program.

_____ Name/Relationship	_____ Phone Number	<input type="checkbox"/> #1 contact if I cannot be reached in case of an emergency
_____ Name/Relationship	_____ Phone Number	<input type="checkbox"/> #2 contact if I cannot be reached in case of an emergency

Photography Release

I authorize the Camp DaVinci program to obtain, store and/or use (without payment) any photographs, slides and/or videotapes of my child for public relations, marketing/advertising, and/or internal training purposes.

Parent/Guardian Signature Date

Emergency Medical Consent

In the event that reasonable attempts to contact me and the two alternate individuals that I have designated at the phone numbers that I have provided on this form have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the physician, dentist, and/or hospital, as applicable, listed below:

_____ Preferred Physician	_____ Phone Number
_____ Preferred Dentist	_____ Phone Number
_____ Preferred Hospital	_____ Phone Number

In the event that the designated preferred physician, dentist, and/or hospital, as applicable, is not available. I hereby give my consent for the administration of any treatment deemed necessary by another licensed physician or dentist at any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists (as applicable), concurring in the necessity for such surgery, are obtained before surgery is performed.

Liability Waiver (Must be signed in order for child to participate in the program.)

I am the parent/legal guardian of _____ ("Child"). On behalf of me and Child, and our respective heirs, we acknowledge and agree that there is a risk of serious injury and/or loss associated with Child's participation in the Camp DaVinci program (the "Program"). As a condition of Child's participation, we assume that risk and forever waive and agree to hold Camp DaVinci and its shareholders, directors, officers, employees, and agents harmless from any and all claims, liabilities, and/or damages arising out of Child's participation in the Program. I understand that Child will not be permitted to participate in the Program without signing this Agreement.

Parent/Guardian Signature Date

Child's Name

Emergency Medical Information

Allergies (food, medication, etc.): _____

Activity restrictions or precautions: _____

List any medication child is currently taking: _____

- My child has an EpiPen® syringe to be administered in case of severe allergic reactions.
- My child is carrying an inhaler and is authorized to self-administer as needed. (Physician's order has been completed at the bottom of this form.)

List any special needs or important information about your child's medical history/behavior: _____

Is there anything specific we can do to help make your child's experience more successful? _____

I confirm that the information provided above is accurate and complete.

Parent/Guardian Signature Date

Emergency Medical Refusal (Do not complete if consent was given above).

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

Parent/Guardian Signature Date

Physician's Order for Prescribed Oral Medication

All medication must be delivered in the original container in which it was dispensed and administered by a pre-authorized individual designated by the parent/guardian. **No member of the Camp DaVinci program is permitted to administer medication.**

I have arranged, and hereby authorize, the administration of prescribed medication for my child to be handled as follows:

Name of Medication

Dosage

Date of Authorized Individual to Administer Medication

Date(s) and Time(s) of Administration (by aforementioned individuals)

Name of Issuing Physician

Issuing Physician Emergency Phone Number

Significant side effects (adverse reactions) that should be reported to the physician: _____

Special instructions for use of drug, including storage: _____

Issuing Physician Signature

Parent/Guardian Signature