Lakewood City Schools
Community Recreation and Education Department

Child Information Form

Camp-Can-Do/S.T.O.P.

Children will NOT be accepted at camp without a completed CHILD INFORMATION FORM on file.

PARTICIPANT INFORMATION (PLEASE PRINT)

NAME_____ SEX: M F

ADDRESS: _____
House # Street City Zip

HOME PHONE NUMBER: _____

BIRTHDATE:_____ AGE: _____ CURRENT GRADE: _____ SCHOOL: _____

Please state any additional funding for camp (ie MRDD, School District) and amount:

Funding Source:_____ Amount:_____

Please circle which camp your child will attend:

Camp-Can-Do (Ages 5-13) **S.T.O.P (Ages 14-22)**

Please circle which session(s) your child will attend:

Session 1 CCD **Session 1 S.T.O.P**

Session 2 CCD **Session 2 S.T.O.P**

Session 3 CCD **Session 3 S.T.O.P**

Session 4 CCD **Session 4 S.T.O.P**

My Child's T-shirt size is (please circle): YM YL AS AM AL XL
I understand each child will receive a T-shirt to wear on field trips.

SECTION I: EMERGENCY CONTACTS

EMERGENCY PHONE NUMBERS

Mother/Guardian Name: _____ Father/Guardian Name: _____

Mother/Guardian Cell/Pager: _____ Father/Guardian Cell/Pager: _____

Mother/Guardian Work: _____ Father/Guardian Work: _____

Emergency Contacts: List the name(s) of *other local persons* who you want to be contacted in the event of an emergency or illness if the parent/guardian cannot be reached. Persons listed should be able to assist in locating the parent/guardian and at least one person listed must be able to take responsibility for the child in cases where the parent/guardian can not be located.

Name: _____ Name: _____

City, State, Zip Code: _____ City, State, Zip Code: _____

Telephone Number: _____ Telephone Number: _____

Relationship to Child: _____ Relationship to Child: _____

COMPLETED FORM DUE JUNE 1

SECTION 2: CHILD'S MEDICAL INFORMATION

Name of Physician/Clinic Hospital: Physician Phone:

Name of Dentist: Dentist Phone:

Hospitalization Insurance:

Name and dosage of any medication taken on a regular basis*:

name ***dosage***

****Please complete separate permission to administer medication sheet if medication is needed during Camp-Can-Do/S.T.O.P hours.***

Allergies (food, medication, & environmental) and precautions, reactions, and treatment:

Medications, food supplements, modified diet currently being administered:

Please note any special needs your child has or services he/she requires (i.e. AD/HD, Autism, Diabetes, sun sensitivity, etc.)

Chronic Physical Problems:

Any additional health or enrollment information you feel we should know about your child:

SECTION 3: EMERGENCY AUTHORIZATION

I give the Lakewood Board of Education, Lakewood Community Recreation and Education Department, my permission to have my child transported to (Hospital or Clinic) for emergency medical care or to (Dentist, if applicable) for emergency dental care, or to the nearest available source of assistance.

☐ **YES** ☐ **NO**

SECTION 4: AUTHORIZATION FOR RELEASE

I hereby authorize the Lakewood Community Recreation and Education Department and Camp-Can-Do/S.T.O.P. to release my child to all individuals listed in Section 1: Emergency Contacts and to the following individuals. In addition, I understand that for safety purposes, a photo identification will be requested for verification purposes.

Name: Name:

Relationship: Relationship:

Telephone Number: Telephone Number:

Denial of Authorization for Release

Name: Name:

Relationship: Relationship:

I HEREBY authorize the Lakewood Community Recreation and Education Department to allow my child, to participate in all Camp-Can-Do/S.T.O.P. activities including but not limited to field trips, swimming, arts and crafts, playground and park activities.

I HEREBY acknowledge that I am responsible for understanding the information in the Lakewood Community Recreation and Education Department Camp-Can-Do or S.T.O.P. Parent Handbook as they relate to my child's enrollment in the program. I HEREBY agree to comply with all procedures, policies, and conditions contained in the Parent Handbook, and I understand that my failure do so may result in termination of my child's participation in the program. Copies of the Parent Handbook can be found at the Recreation Department or online at www.lakewoodrecreation.com.

By registering for any Lakewood Community Recreation and Education Department program, registrants agree to the Lakewood City Schools Community Recreation and Education Department Program Registration Wavier & Consent Policy. A copy of the policy is available at the Lakewood Community Recreation and Education Department, in the Community Education seasonal booklet, or online at www.lakewoodrecreation.com.

PARENT/GUARDIAN SIGNATURE Date

COMPLETED FORM DUE JUNE 1

CAMPER CARE QUESTIONNAIRE

ALL INFORMATION MUST BE COMPLETED. PLEASE USE ADDITIONAL PAPER IF NEEDED.

Camper's Name _____ Nick Name _____

Type of Disability _____

ANY SPECIAL CONCERNS/RESTRICTIONS?

_____

_____

For transportation, does your camper use a wheelchair? YES NO

Does camper need 1:1 supervision? If so, please explain _____

_____

LANGUAGE AND COMMUNICATION: Please check all that apply

___ Uses sign language
___ Has difficulty speaking
___ Understands verbal instructions
____ Use Communication Board
____ Has difficulty being understood
____ No Communication Needs

Please describe special words and phrases used at home, if campers use eyes for yes/no, or other techniques

COMMENTS:_____

_____

EQUIPMENT: Please check all that apply

____ Able to walk alone
____ Wheelchair/Power
____ Crutches or cane
____ Hearing Aide
____ Braces
____Wheelchair/Manual
____Needs assistance pushing wheelchair
____Walker
____ Eyeglasses

Please describe frequency of use of appliances. Please do not send appliances to camp if the camper does not currently or routinely use.

COMMENTS:_____

_____

PERSONAL CARE: Please answer all questions by checking either YES or NO

Uses toilet independently YES___NO___
Dresses Independently YES___NO___
Needs lifted onto toilet YES___NO___
Needs help with menstrual cycle care YES___NO___
Needs toilet reminders YES___NO___
Wears diapers YES___NO___

****PLEASE BE SURE TO PROVIDE ENOUGH DIAPERS/DEPENDS AND UNDERGARMENTS. WE WILL NOT PROVIDE THESE ITEMS!**

EATING HABITS: Please check all that apply

___Needs to be fed ___Needs food cut
___Needs help drinking ___Difficulty swallowing
___Special equipment (explain how to use)_____
___Food allergies (what food)_____
___Special diet, food restrictions, etc.
___Other_____

SOCIAL CONCERNS: Please comment about behavior and social skills (reactions to frustration, group participation, peer relations, does camper hit, bite, etc.)

_____

_____

_____

SPECIAL INTERESTS AND SKILLS:

Camper's Favorite Food: _____ Camper's Favorite Snack: _____
Camper's Favorite Sport: _____ Camper's Favorite TV show: _____
Camper's Favorite Movie: _____ Camper's Favorite Book: _____
Camper's Favorite Song: _____

Camper is happiest when: _____
Camper gets angry when: _____
When the camper has done something good, a great reward would be: _____

ADDITIONAL INFORMATION: Please comment about any additional behavior, like/dislikes, or interests that the Camp-Can-Do or S.T.O.P. staff should know about your camper:
COMMENTS: _____

_____

_____

PLEASE READ CAREFULLY: I give consent for my child to participate in the activities of Camp-Can-Do or STOP, with any restrictions noted on this form.

_____

Signature of Parent/Guardian Printed Name Date

LAKEWOOD CITY SCHOOLS
COMMUNITY
RECREATION & EDUCATION
DEPARTMENT

Lakewood Community Recreation and Education Department

Physicians' Questionnaire

Name of Child: _____ Date: _____

Address: _____ Age: _____

Phone: _____

The above-named child will be participating in a special education program which consists of instructional activities such as developmental skills, simple games and swimming, In order for the instructor to structure an individual program of activitiy within the needs, capabilities and limitations of the child, we would appreciate information relative to the questions listed below.

Description of child's medical condition: _____

_____

_____

Will water activities be of any harm to the applicant? _____

_____

What restrictions in terms of physical activity should be observed for this child? _____

_____

_____

In my opinion, the above named boy/girl can participate in this program in accordance with his/her medical condition and restrictions described above.

_____
Signature of Physician

_____
Address of Physician

_____
Phone Number

Please return this form to the Lakewood Community Recreation and Education Department.

1456 Warren Road
Lakewood OH 44107
(216) 529-4081
(216) 529-4464 (fax)

LAKEWOOD CITY SCHOOLS

LAKEWOOD CITY SCHOOLS

Emergency Medical Authorization Form

PLEASE COMPLETE FRONT AND BACK OF THIS FORM

School _____ Student _____

Address _____

_____ Zip _____

Home Phone ( ) _____

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents or guardians cannot be reached.

RESIDENTIAL PARENT OR GUARDIAN

Mother's Name _____ Daytime Phone ( ) _____

Cell Phone ( ) _____

Father's Name _____ Daytime Phone ( ) _____

Cell Phone ( ) _____

Other's Name _____ Daytime Phone ( ) _____

Cell Phone ( ) _____

*** PRIMARY PHONE NUMBER TO CALL IN CASE OF EMERGENCY: ( ) _____**

Name of Relative or Childcare Provider:

_____ Relationship _____

Address _____ Phone _____

_____

PLEASE COMPLETE FRONT AND BACK OF THIS FORM

MU-SSM-12
Rev. 6/01

Student Services Department

Child's Name _____ Birthdate _____ Homeroom No. _____ LHS Only _____

LAST FIRST HOUSE NUMBER

PART I OR PART II MUST BE COMPLETED

PART I – *TO GRANT CONSENT*

I hereby *give* consent for the following medical care providers and local hospital to be called:

Doctor_____ Phone ( ) _____

Dentist_____ Phone ( ) _____

Medical Specialist_____ Phone ( ) _____

Emergency Room

Local Hospital_____ Phone ( ) _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for

(1) the administration of any treatment deemed necessary by above named doctor, or in the event that the designated preferred practitioner is not available, by another licensed physician or dentist; and

(2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

* **Facts concerning the child's medical history, including *allergies*, *medications being taken*, and any *physical impairments to which a physician should be alerted*:**

_____

_____

_____

Date_____ Signature of Parent/Guardian_____

Address_____

_____

PART II – *Refusal to Consent*

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 the following action:

_____

_____

Date_____ Signature of Parent/Guardian

_____

Address_____

_____

To Be Completed By Parent & Physician If Medication is Taken at School

ADMINISTRATION OF PRESCRIBED AND OVER-THE-COUNTER MEDICATION TO STUDENTS

Lakewood City Schools

I. Student Name_____ School_____ Grade_____ D.O.B._____

Address_____ Day Phone_____ Evening Phone_____

MEDICATION

(Section II – Information to be completed by Prescriber)

II. Name of Prescribed or Over-the-counter Medication and Dosage_____

_____

_____

☐ Patient may carry and administer own: Inhaler ☐ Epi-Pen ☐ Ana-Kit ☐ Yes____No____
This medication can be safely administered by non-medical personnel Yes_____No_____
Number of time or intervals medication is to be administered_____
Date administration is to begin and end_____
Adverse or severe reaction that should be reported to the prescriber_____
Special instructions for administration of medication_____

_____

Prescriber's Name_____ Prescriber's Phone_____

Prescriber's Signature_____ Date_____

Amended S.B. 262
Section 3313.713

Parent agrees to inform the principal of any revision to the prescriber's prescription.

ONE MEDICATION PER CARD

Release of Medical Liability

We hereby authorize and consent to the administration of prescribed/over-the-counter medication to our child, _____ at _____ School by the officers and employers of the Lakewood Board of Education. This consent is in addition to any consent we may have given in the Emergency Medical Authorization Form prescribed by Section 3313.172 of the Ohio Revised Code. The attached statement from our child's physician fully describes the nature of the prescribed medication, dosages, and times for administration.

Please regard our signatures below as our assurance that we release the Lakewood Board of Education and any and all of its officers and employees from any and all liability for injury or damages which might or could be a consequence of or failing to administer such prescribed medication to our child. The school officers or employees cannot be responsible for any adverse reactions to the medication or its effectiveness.

Further, we agree to indemnify and hold harmless the board of Education and any and all of its officers and employees from any and all claims for injury or damage, loss for bodily injury, illness or death which might or could be a consequence of or failure to administer such medication and against loss from any and all further claims, demands, and actions at law or in equity that may hereafter at any time be made or brought by our child or anyone on our child's behalf for the purpose of enforcing a future claim for damages on account of any injury sustained in consequence of or failure to administer such medication.

Medication must be brought in the container in which it was dispensed to the principal or designee by the ***student's parent, guardian, or other person in charge of the student.***

_____ _____ Day Phone _____
Parent/Guardian's Signature Date Evening Phone _____

** If student is asthmatic, please complete Asthma Action Plan For School on reverse side.*

LAKEWOOD CITY SCHOOLS

ASTHMA ACTION PLAN FOR SCHOOL

STUDENT NAME _____ D.O.B. _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Please circle student's known asthma triggers: **pollens** **stress/anxiety** **cold air** **exercise** **other** _____

allergy (please specify) _____

Current medications for asthma control: _____

_____

Asthma medication to be given at school: _____

_____

Is student capable and responsible for self-administering this medication? **Yes** **No**

May student carry inhaler? **Yes** **No**

Note: The Lakewood City School District may choose to follow more restrictive procedures regarding student's self-administration..

If an asthma attack occurs at school, follow these steps:

1. _____
2. _____
3. _____
4. _____

Other special instructions: _____

Date: _____ **Health Care Provider Signature:** _____

TO BE COMPLETED BY PARENT/GUARDIAN

I understand that:

- If symptoms are not relieved by steps taken above and indicate the need for emergency care, school personnel will activate the 911 emergency system.
- If my child does not keep an inhaler in the health office and/or self-administers medication in locations other than the health office, it is my responsibility to review with my child when he/she should come to the health office for additional medical assistance.
- If I am not available at numbers listed on reverse side side, contact:

1) Name _____ Phone number _____

2) Name _____ Phone number _____

Additional Comments: _____

Parent/Guardian Signature _____ Date _____

TO BE COMPLETED BY SCHOOL **Date received at school** _____

Nurse's Signature _____ **Principal's Signature** _____