Orleans Recreation Department

Summer Program

Additional Information Sheet

Because the more WE know, the Happier YOUR child will be!!

Child's Name: _____ Nickname: _____ Age:_____

General Information:

Participant's Summer Address: _____

Mother's/Guardian 1:	Father's/Guardian 2:
Full Name: _____	Full Name: _____
Relationship to child: _____	Relationship to child: _____
Home Phone #_____	Home Phone # _____
Work Phone #_____	Work Phone # _____
Cell Phone # _____	Cell Phone # _____

Medical History

Please note that there is NOT a medical professional on staff during the program operating hours.

In order to better serve your child, please indicate in detail any needs, disabilities, or concerns that your child would benefit from accommodations or modifications (include hearing aids, glasses, contacts, braces, wheelchair, etc.):

_____

_____

_____

Does your child have difficulty in any of the following areas? (Please circle any/all that apply.)

Neurological Orthopedic Hearing Vision Motor Impairment

Additional information: _____

Emergency Contacts:

In the event that a Parent or/and Guardian cannot be reached please list two additional contacts:

Emergency Contact #1_____ Phone(c)_____ Phone(H)_____

Relationship_____

Emergency Contact #2_____ Phone(c)_____ Phone(H)_____

Relationship_____

Allergies

Food (please list and describe reaction): _____

Medication(s): _____

Other (please list): _____

Self-Administered Medication:

Program participants carrying any self-administer emergency medications [such as epinephrine and albuterol inhaler] must notify staff of the storage plan for the medication and complete the waiver below. In addition, must provide a doctor's note with dosage. PRIOR TO THE START OF THE PROGRAM. Please note: ***all controlled substances are PROHIBITED from the program.***

The undersigned parents/guardians ("Parents") hereby authorize the Orleans Recreation Department to allow my child to self-administer the medication(s) stated below ("Medication") and represent to the Department that the history stated below of the child's experience with the illness being treated by the Medication is accurate and complete. The Parents also authorize the Orleans Recreation Department to implement a plan of action for addressing any emergency situation which may arise as a consequence of the Child self-administering the Medication. We acknowledge that the medication must be carried in its original labeled container whether prescription or over the counter. The Orleans Recreation Department hereby notifies the Parents/ Guardians that neither the Town of Orleans, its employees nor its agents shall incur any liability as a result of any injury arising from the self-administration of the Medication by the Child, and the Parents/ Guardians hereby acknowledge that no such liability shall exist, and on behalf of themselves and the Child hereby waive any such liability. Furthermore, the Parent/ Guardians hereby agree to indemnify and hold the Town of Orleans, its employees and its agents harmless against any claims whatsoever arising out of the self-administration of the Medication by the Child.

Medication: _____ Dose:_____

Parental Signature: _____

Social / Emotional:

What is your child's 2 most favorite outdoor activities?

1) _____ 2)_____

Please circle which best applies to your child. **Extreme**, **Mild**, and/or **Low** ***Sensitivity*** for the questions below regarding your child to allow our staff members to understand and help your child better in these potential circumstances.

Extreme Mild Low Frightened of thunder, lightning, or bad weather?

Extreme Mild Low Poor with transitions (moving from one activity to the next or abrupt changes in activities)?

Extreme Mild Low Fear of tall or scary amusement park or water rides?

Extreme Mild Low Uncomfortable with water activities or activities that may involve getting dirty or messy?

Extreme Mild Low Bathroom issues with long car/bus trips?

Extreme Mild Low Loud noises and/or children yelling?

Extreme Mild Low Other :please specify and explain below if needed;

_____

If you circled EXTREME to any of the above, would like to provide more information on an above subject matter, and/or can offer helpful strategies to use with your child in these cases, please elaborate in further detail below:

_____

_____

Do you have any family concerns that you would like to inform us about?

_____

Y N Is this your child's first summer at this program?

Y N Do you have any concerns as to whether your child will make friends easily?

Behavioral

Does your child have any behavioral difficulties? NO YES (Please circle any/all that apply.)

Hitting Pinching Kicking Tantrums Non-Compliant Biting Hyperactivity Screaming

Task Refusal Running Away Short attention span Self-stimulation Crying

Additional information:

_____

_____

Is your child currently on a behavior modification plan at school? NO YES

Is your child currently on a behavior modification plan at home? NO YES

Any additional comments, requests, or concerns that you would like to let us know about? Please understand we will do our best to accommodate you, but please understand that we cannot guarantee it.

_____

_____

Exchange of Custody:

Do you allow your child to walk or bike to the program? YES NO

If yes, please sign the waiver:

By signing this wavier, I authorize my child (listed above) to walk home, or bike home at the conclusion of the Orleans Recreation Department Program. *Please note that this permission slip grants permission for this child to leave program without adult supervision.*

I understand that by signing this waiver and allowing my child to walk home or bike home. I have designated the Orleans Recreation Department is not responsible for monitoring the safety of my child after she or he leaves the program.

Please note :children *may walk home or bike home only when this waiver/permission has been signed and dated by a parent/guardian.*

_____ _____

Parent/ Guardian signature ***Date***