



# Sylvania Recreation

## Summer Days Camp Release Form

**Participant Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Parent Guardian Name:** \_\_\_\_\_

I certify that \_\_\_\_\_, as the parent/guardian of \_\_\_\_\_, give my consent to Sylvania Recreation and its medical representative to obtain medical care from any licensed physician, hospital, or clinic for the above mentioned participant for any injury that could arise from the participation of the Summer Days Camp sanctioned events. I authorize that he/she will participate in all sanctioned Sylvania Recreation activities or events. These activities or events include, but are not limited to, sports, art/crafts, traveling with the camp on a bus to and from that day's field trip location, and walking to and from scheduled activities. I understand that SRC staff may take digital images or video to use for promotion of programs and events on websites, commercials, or other promotional materials. I fully permit SRC use of any images of me/my child(ren) and waive any claim for such use.

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

If said participant is covered by any insurance company, please complete the following:

**Insurance Company:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Medical History

Please describe any problem and its complications for proper first aid treatment on the back of this form.

Head Injury	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>			_____
Diabetes	<input type="checkbox"/>	Neck/Back injury	<input type="checkbox"/>	Other	<input type="checkbox"/>	_____
Fainting Spells	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>			_____

Does your child currently take any medications? If yes please list all medications being taken below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has a doctor placed any restrictions on your child's activity? Yes\_\_\_\_ No\_\_\_\_

## Emergency Contact Information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Hospital of Choice: \_\_\_\_\_

## Authorized Pick-Up Contacts

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_