CITY OF MOUNT DORA

Flag Football Camp Registration Form

Participants Name: _____

Gender: ☐ Male ☐ Female Date of Birth: _____ Age:_____ Grade: _____

Address: _____

City: _____ State: _____ Zip: _____

Please ***circle*** the weeks you be attending:

Week 1 (6/1-6/5)	**Week 2** (7/6-7/10)

Parent/Guardian Name: _____

Home Phone: _____ Work Phone:_____

Cell Phone:_____ Date of Birth: _____

Place of Employment:_____

E-mail Address:_____

Parent/Guardian Name: _____

Home Phone: _____ Work Phone:_____

Cell Phone:_____ Date of Birth: _____

Place of Employment:_____

E-mail Address:_____

Emergencey Contact (other than parent):_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone:_____

Cell Phone:_____ Date of Birth: _____

Office use only

Registration taken by: _____ Date: _____

Shirt Size: _____

Amount Received: _____ ☐ **Check** ☐ **Cash** ☐ **Credit**

Copy of ID: ☐ **Yes** ☐ **No**

CITY OF™ MOUNT DORA

Medication

Does the participant have any known medical conditions (ADD/ADHD/Allergies etc.)
o No o Yes *(if yes please explain)*

_____

_____

Will the participant require medication during the program? ☐ No ☐ Yes

(if yes please fill out the rest of this page)

Name of Medication:_____

Amount/Dosage:_____ Route of Administration:_____

Frequency to be Administered:_____

Prescribers Name: _____

Prescribers Phone Number:_____

General Information:

- If a participant requires medication at anytime while in our program, a **Written Medication Consent Form** must be completed and signed by a physician and parent.
- All medication will be self-administered, except the Epi-Pen.
- Program staff will lock up the medication or equipment.
- Program staff will contact parent immediately if any problem arises concerning this medication or equipment.
- Program staff will not be responsible for equipment if broken.
- If the Division Nurse, or designee, has any concerns with the medication or specialized procedures request, they will discuss them with the parent and/or physician.
- Accommodations will be made as necessary.
- If there is a change in the medication, dosage and/or specialized procedure, an updated **Written Medication Consent Form** must be completed and submitted for approval before the medication or specialized procedure can be self-administered.

Medication:

- Parent will measure medication dosage at home and submit the exact weekly dosage needed (this includes the splitting of pills/tablets).
- Parent will be required to transport/submit weekly dosage of medication to the Program staff in the appropriate labeled container.
- Parent will verify the amount of medication being dropped off with Program staff and documentation will be noted. On the participant's last day in attendance for each week, parent and staff will verify any unused medication being returned.

I agree to adhere to the procedures stated above.

_____

Parent or Legal Guardian's Signature Date

CITY OF™ MOUNT DORA

Authorized Pick-Up List

(Other than parents)

Name:____

Gender: ☐ Male ☐ Female Date of Birth:______________________

Address: ____

City: ____________________ State: ______________ Zip: ______________

Home Phone: _______________________ Work Phone:____________________

Cell Phone:____________________ E-mail address: __________________________

Name:____

Gender: ☐ Male ☐ Female Date of Birth:______________________

Address: ____

City: ____________________ State: ______________ Zip: ______________

Home Phone: _______________________ Work Phone:____________________

Cell Phone:____________________ E-mail address: __________________________

Name:____

Gender: ☐ Male ☐ Female Date of Birth:______________________

Address: ____

City: ____________________ State: ______________ Zip: ______________

Home Phone: _______________________ Work Phone:____________________

Cell Phone:____________________ E-mail address: __________________________

Name:____

Gender: ☐ Male ☐ Female Date of Birth:______________________

Address: ____

City: ____________________ State: ______________ Zip: ______________

Home Phone: _______________________ Work Phone:____________________

Cell Phone:____________________ E-mail address: __________________________

CITY OF MOUNT DORA

Wavier & Release of Liability

I (We), _____ & _____, parent(s) / guardian(s) of _____ for myself, my heirs and personal representatives, hereby freely and voluntarily assume all liabilities, risks, injuries, and hazards incidental to participation in this Parks & Recreation Department Program whether due to my (our) negligence or the negligence of others including transportation to or from said activity. I (we) do hereby give consent for my (our) child named above to participate in scheduled on-site experiences and off-site field trips as part of this program. Further, I (we) give my (our) consent to the City of Mount Dora Parks and Recreation Department or its representatives, to acquire emergency medical treatment for my (our) child from medical personnel/facilities should that become necessary for any reason. I (We) do hereby waive, release, and agree to hold harmless to the City of Mount Dora Parks & Recreation Department, its officers, agents, employees, the organizers, sponsors, activity supervisors, co-sponsoring organizations, and participants for any claim, demand liability, costs, suits, charges, or compensation for loss of injury of any kind arising out of a loss or an injury. I (We) acknowledge that the City of Mount Dora Parks & Recreation Department will not assume any costs relating to any injury while my (our) child is involved in this activity. I (We) acknowledge that, absent this express Assumption of Risk, the City of Mount Dora Parks & Recreation Department or other sponsors of the activity would not have offered me (us) access to this activity because of unacceptable exposure to liability claims or the expense of providing a program that is risk-free.

In order to expedite the care of my (our) child named above, I (we) give permission for the appropriate medical personnel and staff to initiate treatment immediately upon arrival at the appropriate facility. I (we) agree to be financially responsible for my (our) child's treatment. I (we) also request that I (we) (or the alternate emergency contact person listed) be notified of my (our) child's condition and admission as soon as possible.

In the event of a life-threatening accident or illness, I (we) understand that The City of Mount Dora Parks and Recreation Department or its representatives, may contact 911 Services immediately. I (we) agree to be financially responsible for my (our) child's care and treatment.

I also hereby give permission for images of my child and I, captured during regular and special activities through video, photo and digital camera, to be used solely for the purposes of promotional material, social media and publications, and waive any rights of compensation or ownership there to.

_____

Parent/Guardians Signature **Date**

_____

Insurance Company Policy Number

_____

Name on Plan