Camp Authorization

Please check camp and all sessions that your child(ren) have registered for and indicate which days of the week they will be in attendance:

☐ **Kidventure Kamp** ☐ **Junior Camp** ☐ **Mor Gro** ☐ **Teens**

☐ **Camp S'More** ☐ **Extended** ☐ **Rise-n-Shine**

☐ **Sess 1**	☐ **Full-Time**	☐ **Part-Time**	**Days: M T W Th F**
☐ **Sess 2**	☐ **Full-Time**	☐ **Part-Time**	**Days: M T W Th F**
☐ **Sess 3**	☐ **Full-Time**	☐ **Part-Time**	**Days: M T W Th F**
☐ **Sess 4**	☐ **Full-Time**	☐ **Part-Time**	**Days: M T W Th F**

General Information

Childs Name:	**Birthday:**	**Grade entering next Fall:**
Address:	**City:**	**Zip:**
Home Phone:	**Email:**	**School:**
Mother's Name:	**Work Phone:**	**Cell:**
Father's Name	**Work Phone:**	**Cell:**

Allergies, diseases, disorders, or disabilities:_____

Activities child should not participate in:_____

Special circumstances the Park District should be aware of:_____

Does your child require special assistance? ☐ No ☐ Yes Explain:_____

Does your child require medication during program hours? ☐ No ☐ Yes

If yes, medication dispensing information form must be completed

Indicate mode of transportation leaving camp: ☐ Parent ☐ Car Pool ☐ Bus ☐ Bike ☐ Walk

EMERGENCY CONTACTS: Include all authorized individuals to be contacted if unable to reach parents.

1. Name _____Work Phone_____home/cell_____
2. Name_____Work Phone_____home/cell _____

AUTHORIZED INDIVIDUALS: Include all authorized individuals to pick up child from program other than parents or emergency contacts. Children will **ONLY** be released to persons listed below.

1. Name _____Work Phone_____home/cell_____
2. Name_____Work Phone_____home/cell_____

EMERGENCY TREATMENT RELEASE: As a parent and/or guardian, I authorize that in a medical emergency regarding my minor child, that the local emergency medical service is to be contacted. If, as determined by the local emergency medical service, my child needs emergency medical treatment and needs to be transported to an emergency care center, I authorize treatment and transportation. If in the opinion of the attending physician at the emergency care center that further treatment is necessary, I authorize the treatment of my child. However, a reasonable effort should be made to contact myself and/or if need, the alternate emergency contacts listed. I declare that I exercised my own judgment in deciding whether to sign this agreement and I further declare that my decision to sign was not based on or influenced by any declaration or representation of the Morton Grove Park District or its employees, agents or instructors. In addition, I agree that I will be responsible for payment for any and all medical services provided.

Signature of parent/guardian:_____Date:_____