



City of Homestead
Parks, Recreation & Open Spaces Department

Office Use Only

Camp Group:

SUMMER CAMP REGISTRATION FORM

Registration Procedure: Please complete all applicable information. Registrations received after 5:00 p.m. will be processed on the next business day. **Method of Payment:** Check or Money Order

***Please Print All Information**

| | | | |
|--|--------------------------|---------------|------|
| Participant's Last Name: | | First Name: | |
| Street Address: | | City: | Zip: |
| Sex: _____ Male _____ Female | DOB: ____/____/____ | | Age: |
| <u>T-Shirt Size</u> | <u>Youth:</u> | <u>Adult:</u> | |

Household Information

| | | | |
|--------------------------------------|--|-------------|----------------|
| <u>Primary Contact</u> First Name: | | Last Name: | Home Phone: |
| Work Phone: | | Cell Phone: | Email Address: |
| <u>Secondary Contact</u> First Name: | | Last Name: | Home Phone: |
| Work Phone: | | Cell Phone: | Email Address: |
| Address (if different): | | City: | Zip: |
| Emergency Contact: | | Cell Phone: | |

Authorized to Pick Up Child

| | | |
|---------------------|---------|------|
| First and Last Name | Phone # | DL # |
| First and Last Name | Phone # | DL # |
| First and Last Name | Phone # | DL # |

Special Needs/Limitations/Allergies/Notes

| |
|---|
| _____ Medical _____ Behavior _____ Dietary _____ Allergies _____ Sensitivities _____ Other |
| Explain in this section: |

See Attached Waiver



City of Homestead
Parks, Recreation & Open Spaces Department
Summer Camp

Physician Request for Self-Administration of Medication

Name of Student

Date of Birth

To: City of Homestead's Parks, Recreation and Open Spaces Department

The above named child has _____
Name of Illness or Medical Condition

I am requesting that the above named student be allowed to take the following medication during Camp hours:

Name of Medication: _____

Type of Medication (tablet, liquid, capsule, inhaler, injectable):

Dosage Time(s) to be taken or administered:

Possible side effects:

I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision. (Check one):

Yes No

For ASTHMA and ALLERGY CONDITIONS ONLY: I also request that this student be allowed to carry the above described medication on their person during Camp hours and facilitate the self-administration of the medication as needed. (Check One):

Yes No

Signature of Physician

Date

Name of Physician

Address

Emergency telephone number

City, State, Zip

CITY OF HOMESTEAD

PARKS AND RECREATION DEPARTMENT

SUMMER CAMP

WAIVER AND MEDICAL AUTHORIZATION FOR MINORS

(To be completed by Parent or Guardian)

As the parent or legal guardian of _____, a minor child participating in programs, activities, or using any facilities, premises, or equipment of the City of Homestead, I hereby agree to the following terms and conditions:

1. Waiver and Release: I voluntarily waive, release, and discharge any and all claims for damages for personal injury, property damage, or wrongful death which may arise from or relate to the participation of the above-named minor in any program, activity, event, or use of facilities, equipment, or transportation provided, organized, or endorsed by the City of Homestead, including its elected and appointed officials, employees, agents, contractors, and representatives (collectively, the "Indemnitees"), regardless of whether such injury or damage is caused in whole or in part by the negligence of the Indemnitees.
2. Medical Authorization: I authorize the Indemnitees and their agents to seek emergency medical treatment for the above-named minor and to transport or arrange for transport of the minor to an appropriate medical facility if, in their judgment, medical treatment is necessary and the parent or guardian cannot be contacted in a timely manner. I understand that the Indemnitees assume no responsibility for the medical care or transportation provided, and I agree to be financially responsible for any resulting medical charges.
3. Acknowledgment of Responsibility: I understand that the City of Homestead and the Homestead Community Center are not responsible for the loss of personal items, including money, and that participants are discouraged from bringing valuables to programs, activities, or field trips.
4. Photo and Media Release: I grant permission to the City of Homestead and its authorized representatives to photograph, video record, and otherwise capture the likeness of the above-named minor during participation in any program, activity, or event. I further authorize the City to use such images, video, or audio recordings in promotional materials, publications, social media, websites, and other media outlets promoting the City's programs, activities, or initiatives. I understand that no compensation will be provided for such use and that all images and recordings shall become the property of the City of Homestead.

Signature of Parent or Guardian: _____

Printed Name: _____

Date: _____

Witnessed:

By: _____ Name: _____ Date: _____