

PROGRAM NAME: _____

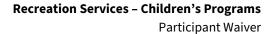
Recreation Services - Children's Programs

PROGRAM DATE: ______

Participant Waiver

	T			
	Child's Name:			
	First Name	Last Name		
Participant	Child name preference:	Age:		
	Birthdate (DD/MM/YYYY):	Care Card #:		
	Child's 1 st Language:	_ Child's 2 nd Language:		
Ра	Home Address:			
	Does your child have a life-threatening alle	ergy? □ Yes or □ No (check one)		
	What is the life-threatening allergy to?	EpiPen Location:		
Contacts	Primary Contact (Parent/Guardian Name):			
	Phone # (Primary):	(Secondary):		
	Emergency Contact:	Relationship:		
	Phone # (Primary):	(Secondary):		
_	I hereby authorize the following people to pick up my child, at the program location in the event			
tior	parent(s)/guardian(s) are unable to and have	contacted the program staff prior to pick up.		
p Authorization	Name:	Phone #:		
	Name:	Phone #:		
Pick U	Name:	Phone #:		
-				
	Name:	Phone #:		
	I, the undersigned, parent/guardian do hereb	y agree to all the individual(s) names herein to be		
	I, the undersigned, parent/guardian do hereb photographed and pictures to be used solely			
Photos F	I, the undersigned, parent/guardian do hereb	y agree to all the individual(s) names herein to be		

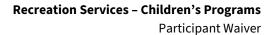
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	Please ensure all information is filled out as this information is used is for staff to provide medical treatment and information for your child in the event of an illness or injury.				
Medical Information	Does your child: Have any medical conditions (i.e. asthma, diabetes)? □ Yes or □ No if yes please explain below: ———————————————————————————————————				
	Take any medication (include type, dosage, times of self-medication)? □ Yes or □ No if <u>yes</u> please explain below:				
	Have any allergies (include those to food, medication, sunscreen and environment)? □ Yes or □ No if yes please explain below:				
	Have any limitations that would mean the child could not participate in activities?				
Me	Have any fears that staff should be aware of (e.g. water, bees)?				
	Medical Release: It is our policy to notify a parent when a child is ill or needs medical attention. In the event we cannot contact you and we need to get immediate help for your child, we require a signed consent to do so. 1. I give consent for my child to be taken to the nearest emergency medical centre by ambulance when I cannot be contacted. 2. I give consent for my child to receive medical treatment.				
	Parent/Guardian Signature: Date: Date:				
	Witness:				

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Date

	Does your child know how to swim? □ Yes (independently) □ Yes (with a life jacket) □ No (check one)					
mation	Do you give permission for staff to administe	er sunscreen to your child?	□ Yes or □ No (check one)			
	Do you give permission for staff to administe	er bug spray to your child?	□ Yes or □ No (check one)			
Additional Information	Please list any family information or special instructions the program staff should be aware of while your child is in care:					
Addit	Please list any other comments or concerns	that you have:				
a 5						
Walk Home Authorization	PARTICIPANTS 10 YEARS OF AGE AND OLDER By signing below, I give permission to allow my child/ren to walk home/leave after the program is					
Wal	concluded unaccompanied by a parent or g	uardian.	□ Yes or □ No (check one			
	I consent to my child's participation in the Program. I am aware that there are risks associated with the participation in the program, including the risk of injury, and I consent to my child's participation in spite of such risks. I acknowledge that it is my responsibility to advise the City of Maple Ridge of any medical or other conditions which may affect my					
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	child's participation in Maple Ridge Parks, Recreation & Culture programs and have listed them above. I have read this form and understand and accept its terms.					
- F	Parent/Guardian Signature	 Parent/Guardian Pri	 nted Name			

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