

PROGRAM NAME: _____ **PROGRAM DATE:** _____

Participant	Child's Name: _____ First Name Last Name Child name preference: _____ Age: _____ Birthdate (DD/MM/YYYY): _____ Care Card #: _____ Child's 1st Language: _____ Child's 2nd Language: _____ Home Address: _____ Does your child have a life-threatening allergy? ☐ 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): _____
Pick Up Authorization	I hereby authorize the following people to pick up my child, at the program location in the event parent(s)/guardian(s) are unable to and have contacted the program staff prior to pick up. Name: _____ Phone #: _____ Name: _____ Phone #: _____ Name: _____ Phone #: _____ Name: _____ Phone #: _____
Photos	I, the undersigned, parent/guardian do hereby agree to all the individual(s) names herein to be photographed and pictures to be used solely for the purposes of promoting City of Maple Ridge programs. ☐ Yes or ☐ No (check one)

Medical Information	<i>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.</i> 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 yes 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?
	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: _____
	Witness: _____

Additional Information	Does your child know how to swim? ☐ Yes (independently) ☐ Yes (with a life jacket) ☐ No (check one) Do you give permission for staff to administer sunscreen to your child? ☐ Yes or ☐ No (check one) Do you give permission for staff to administer bug spray to your child? ☐ Yes or ☐ No (check one) Please list any family information or special instructions the program staff should be aware of while your child is in care: _____ _____ Please list any other comments or concerns that you have: _____ _____
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 concluded unaccompanied by a parent or guardian. ☐ 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 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.

Parent/Guardian Signature

Parent/Guardian Printed Name

Date

The personal information on this form is collected in accordance with the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, use or disclosure of this information, please contact the Manager of Legislative Services, at 604-463-5221 or foi@mapleridge.ca.