ANTIOCH CALIFORNIA
OPPORTUNITY LIVES HERE

CAMPER LAST NAME _____

☐ **Check here if your child is registered for Youth Extended Care.**

Antioch Youth Sports Camp- All-Stars Emergency Form

City of Antioch Recreation Department | 4703 Lone Tree Way | Antioch, CA 94531 | 925-776-3050

CAMPER INFORMATION

Child's Name _____

Gender _____ **Age** _____ **Date of Birth** _____ **Grade** _____

Address _____ **City** _____ **Zip** _____

Swim Ability Non-Swimmer Beginner Intermediate Advanced **T-Shirt Size** XS S M L XL AS AM AL

Parent/Guardian #1	*Parent/Guardian #2*
Name _____	**Name** _____
Relationship to Child _____	**Relationship to Child** _____
Address _____	**Address** _____
Daytime Phone _____	**Daytime Phone** _____
Cell Phone _____	**Cell Phone** _____
Email _____	**Email** _____

DESGINATED CHILD PICK-UP AUTHORIZATION LISTING - Must put person other than parent or guardian

First Name _____ **Last Name** _____ **Gender** _____

Relationship to Child _____ **Cell Phone** _____

First Name _____ **Last Name** _____ **Gender** _____

Relationship to Child _____ **Cell Phone** _____

FEE FOR LATE PICK-UP

Parents agree to pick up their children by or before the scheduled release time. A LATE FEE OF $5.00 PER 5 MINUTE INTERVAL PER CHILD WILL BE CHARGED. Late fees are to be paid directly to the City of Antioch.

I have read and understood the Late Fee procedure listed above and agree to the terms and conditions.

Parent/Guardian Signature _____ **Date** _____

CONSENT TO MEDICAL TREATMENT OF MINOR

I hereby authorize any medical doctor, emergency technician, paramedic, nurse, healthcare provider, hospital, or other medical facility to treat my child for any illness, medical complication, allergic reaction, or injury received while my child participates in the City of Antioch Program. I authorize any licensed physician to perform any procedure, including the administration of anesthesia that the physician deems advisable to treat any illness, medical complication, allergic reaction, or injury that my child may experience. I authorize any City of Antioch employee to perform any procedure, including the assistance in the administration of epi-pens or medication (whether over the counter prescription) that I have described in the Authorization for Emergency Care for Children with Severe Allergies/Life Threatening Medical Condition to treat any illness, medical condition, allergic reaction, or injury that my child may experience. I realize that there is a possibility of complications and undesired and unforeseen consequences in any medical treatment and I assume any such risk on behalf of my child. I represent that I am a parent or legal guardian of the child and I hereby agree to defend, hold harmless, and indemnify the City of Antioch, its Council, officers, employees, agents, and volunteers, and event holders, event sponsors, event directors, event volunteers, doctors, emergency medical technicians, paramedics, nurses, healthcare providers, and hospitals or other medical facilities from all liability, loss, costs, claims, or damages whatsoever that may be imposed upon said parties due to the medical treatment, or lack thereof, given to my child.

☐ **Check here if your child requires assistance with the administering of medication during program time.**

Parent/Guardian Signature _____ **Date** _____

PARENTAL CONSENT & DIRECTIONS TO STAFF FOR THE SELF-ADMINISTRATION OF MEDICINES

City of Antioch Recreation Department | 4703 Lone Tree Way | Antioch, CA 94531 | 925-776-3050

Child's Name _____ **D.O.B.** _____

Program / Class _____

Medical Condition(s) _____

Asthmatic: ☐ **Yes** ☐ **No** **Allergies/ Food Restrictions :** ☐ **Yes** ☐ **No**

Allergic Reactions, Signs & Symptoms to Look For _____

_____

_____

Medications : ☐ **Kept at site** ☐ **Brought Daily and Delivered to Instructor**

Name of Medication(s) _____

Form: (liquid, pill, etc) _____

All medications, prescription and over the counter, must be provided to City of Antioch Recreation Department staff in their original packaging, with your child's full name written on the container. Remember to provide medication cups, spoons or other instruments for the medication's administration. The medication dosage must be completed below in the INSTRUSTION section. If additional instructions are required, please attach another sheet.

INSTRUCTIONS: Parents/Guardians - ***Please write specific step-by-step instructions for staff to follow in the event your child has an allergic reaction or displays symptoms of a medical condition. You must confirm these steps with your child's physician or health care provider. By providing these instructions, you are consenting to staff's ASSISTANCE with medical treatment of your child.***

For Example: 1. Administer Epi-pen 2. Administer 2 teaspoons of liquid Benadryl 3. Call 911 4. Call Parents

1. _____

2. _____

3. _____

4. _____