City of Stockton | Community Services | Recreation & Library

AFTER SCHOOL PROGRAM/DAY CAMP/ TEEN REGISTRATION & MEDICAL INFORMATION

Complete and turn in to your preferred Community Center.

☐ After School Program ☐ Day Camp ☐ Teens

☐ Arnold Rue ☐ Seifert ☐ Stribley ☐ Van Buskirk ☐ John Muir (John Muir students ONLY)

Participant's Full Name: ________________________________ DOB: ____________Age:___Gender: ◯ M ◯ F

Street Address: ____ City: ________________Zip: ______________

Attending School : ____Grade: ___________________

INSURANCE CARRIER: ___________________________________ I.D.#: __________________________________

EMERGENCY CONTACT INFORMATION:

Parent/Guardian 1:		Parent/Guardian 2:	
Home #		Home #	
Cell #		Cell #	
Work #		Work #	
Email		Email	
DOB		DOB	

Children must be signed in/out daily by the parents/guardians listed above or assigned individuals below. Individuals listed below must be 18 years of age and possess a valid drivers license and will be required to show their drivers license. LATE FEE: $15 fee per 15 minutes late, will be charged for late pick-ups. No exceptions. NOTE: Persons listed below may be called in an emergency situation if parent(s)/ guardian(s) are not available.

ASSIGNED DROP-OFF/PICK-UP INDIVIDUALS:

Name	Relationship	Home/Cell Phone	Work Phone

Please provide any other information that will assist staff in making your child(ren) have the best experience:___

____

____

____

PARENT/GUARDIAN CONSENT OF WAIVER FOR PARTICIPATION: *I hereby release, discharge and agree not to sue the City of Stockton, its officers, employees, agents, and contractors for any injury or damage to or loss of personal property, or illness, including, but not limited to, communicable diseases such as MRSA, influenza, and COVID-19, arising out of, or in connection with, my participation in the activity/event from whatever cause, including the active or passive negligence of the promoter/organizer or City or any other participant in the activity/event. In consideration for being permitted to participate in the activity/event, I hereby agree, for myself, my heirs, administrators, executors and assigns, that I shall indemnify and hold harmless the City from any and all claims, demands, actions or suits arising out of or in connection with my participation in the activity/event. This form will act as a medical release in the case of an emergency.*

I understand that by participating in this event, that I am giving consent for images of myself and event to be used for promotional purposes or instruction by the City of Stockton.
In case of an emergency or for reasons beyond the City's control, the City reserves the right to cancel the scheduled activity prior to scheduled use without liability. Refunds will be made if cancellation by the City is necessary.

I have carefully read this release, hold harmless and agree not to sue and fully understand it contents. I am aware that this form is a full release of all liabilities and signed by my own free will.

PARENT SIGNATURE: ____DATE: __________

PLEASE COMPLETE THE MEDICAL INFORMATION ON THE BACK SIDE OF THIS FORM

FOR OFFICE USE ONLY: DATE RECEIVED: _________________ FEE ENCLOSED: ________________

CITY OF STOCKTON

AFTER SCHOOL EXPRESS/DAY CAMP REGISTRATION/MEDICAL INFORMATION FORM

The City of Stockton is concerned for the health, safety and inclusion of all children in its care. Accordingly, when a parent(s)/guardian(s) is registering their child in a City of Stockton recreation program we like to have as much information about each child to ensure their experience is as safe and memorable as possible. Please fill out the following health information to assist us. We encourage each parent/guardian to speak with Community Center Staff prior to the start of the program for any questions, or if more information needs to be provided about their child(ren). All information will be kept confidential.

HEALTH & MEDICAL INFORMATION (Please check ALL that apply)

☐ Asthma/Respiratory Condition	☐ Attention Deficit Disorder
☐ Diabetes	☐ Hearing Impaired
☐ Sun Burns Easily	☐ Uses Epi-pen
☐ Unusual Bleeding	☐ Vision Impaired

Seizures ◯ Yes ◯ No **Type & Frequency** ______________________________
____

Bee Sting Allergy ◯ Yes ◯ No **Reaction** ______________________________
____

Food Allergies ◯ Yes ◯ No **List Foods & Reaction** ______________________________
____
____

Medication Allergies ◯ Yes ◯ No **List Meds & Reaction** ______________________________
____
____

Other Conditions: (Please Explain)
____
____
____

Does the child have a disability requiring any accommodations?
If yes, please explain
____
____
____

Children must be able to monitor and administer their own medication.
Is your child taking any medication? ◯ Yes ◯ No
List Medication/Reason/Dosage/Interval:
____
____
____

PARENT SIGNATURE: ______________________________ DATE: ________

CITY OF STOCKTON