

### Solon Recreation Medical Release Form

Camper's Name & Address:		Parent's Names:		
		Home Phone:	Work Phone:	Cell Phone:
2009-2010 Grade:	Age:	Date of Birth:	Gender:	
<i>IN CASE OF EMERGENCY, PARENT TO CONTACT FIRST (Mother or Father):</i>				
Mother's Name:		Home:	Work:	Cell:
Father's Name:		Home:	Work:	Cell:
<i>People to contact in case of emergency, if parents cannot be reached:</i>				
Name:		Phone:	Phone:	Relation:
Name:		Phone:	Phone:	Relation:
LIST ALL ALLERGIES:	1.	2.	3.	
Special precautions or treatments for allergies:				
Other Health Information (including medicines currently being administered)				

**\*\*IMPORTANT:** We strongly encourage you to have your child checked with their doctors before participating in any program.\*\*

#### Part 1 or Part 2 MUST be completed.

<p style="text-align: center;"><b>Part 1 (To Grant Authority)</b></p> <p>In the event that reasonable attempts to contact me at <u>the numbers listed above</u> have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr.</p>	<p style="text-align: center;"><b>Part 2 (Refusal to Consent)</b></p> <p style="text-align: center;"><b>Do not complete part 2 if you have completed part 1</b></p>				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%;">Preferred Doctor:</td> <td>Phone:</td> </tr> <tr> <td>Preferred Dentist:</td> <td>Phone:</td> </tr> </table>	Preferred Doctor:	Phone:	Preferred Dentist:	Phone:	I do not give my permission for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the camp authorities to take no action or to:
Preferred Doctor:	Phone:				
Preferred Dentist:	Phone:				
Or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to					
Preferred Hospital: Or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained before the surgery is performed. Facts concerning child's medical history including allergies, medications being taken, and physical impairments to which a physician should be alerted:	I (we) agree not to hold the Solon Recreation Department responsible for any medical illness effects which occur as a result of this program.				
I (we) agree not to hold the Solon Recreation Department responsible for any medical illness effects which occur as a result of this program					

Parent/Guardian Signature:

Date:

## Solon Recreation Summer / Adventure Camp

Please circle the session you want your child to attend:		1   2   3   4				
Request of friends your child would like to be placed with (limit of two):	1.	2.				
<b>FIELD TRIP PERMISSION:</b>						
I hereby give permission for my child _____ to participate in the 2009 Summer Camp and Adventure Camp field trips.						
Please Circle: YES   NO	My child <u>HAS</u> my permission to ride roller-coasters at any and/or all locations mentioned above.					
Please Circle: YES   NO	My child <u>HAS</u> my permission to ride water slides at any and/or all locations mentioned above.					
<b>CAMP T-SHIRTS:</b>						
One T-shirt is included in the price of camp. Summer Camp campers (K-4) will only need their shirt one day per week. Adventure Camp campers (5 & 6) will need their shirts three times per week. Summer Camp shirts are different than Adventure Camp shirts. Shirts from previous years are not permitted.						
Cost per shirt: March 6 <sup>th</sup> – March 13 <sup>th</sup> - \$8.00 / After March 13 <sup>th</sup> - \$10.00						
Please circle the size below for your child:						
Included in fee:	YS (6-8)   YM (10-12)   YL (14-16)   AS   AM   AL   AXL					
Extras:	YS (6-8)   YM (10-12)   YL (14-16)   AS   AM   AL   AXL	Quantity:                      Fee:				
<b>BUS:</b>						
(only fill out the following if you wish to use the service)						
Address:	Home Phone:	Other Phone:				
Subdivision:	Circle Appropriate Sessions:    1   2   3   4					
<b>***DO NOT WRITE IN THIS BOX***</b>						
	Session 1	Session 2	Session 3	Session 4		Total Due
Name:						
Parent/Guardian Signature: _____			Date: _____			

<b>Don't forget that EXTENDED CARE <u>MUST</u> be pre-paid in order for your children to use this service.</b>
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