



CRPD FITNESS CAMP APPLICATION SUMMER 2023

ALL INFORMATION MUST BE FILLED OUT COMPLETELY AND MUST BE LEGIBLE

Site: (circle only one)

Blackburn

Douglas

Driving Park

Glenwood

Total # in family _____ Yearly Income \$ _____ (AGI – Adjusted Gross Income from Federal Tax form 1040)

1. Child resides primarily with: _____ (circle one) Mother Father Guardian Both

2. Parent #1 Name:

Last

First

MI

Address:

Number & Street

City

State

Zip

Home Phone (____)

Work Phone (____)

Ext. _____

Cell Phone (____)

Email _____

3. Parent #2 Name:

Last

First

MI

Home Phone (____)

Work Phone (____)

Ext. _____

Cell Phone (____)

Email _____

4. Child 1 Name:

Last

First

MI

Gender: (circle one) Male Female

Date of Birth: ____/____/____

Age: _____

Health Conditions (circle all that apply)

Asthma Diabetes Hyperactivity

Allergies: _____

Speech Impairment Hearing Impairment

Medications: _____

Other Illness: (explain) _____

Vision Impaired

Ethnicity: (you must check one)

Hispanic/Latino ☐

Non-Hispanic/Non-Latino ☐

Race: Check All That Apply: African American/Black _____

White _____

Asian _____

Alaskan Native _____

Amer. Indian _____

Native Hawaiian/Other Pacific Islander _____

Other (fill in) _____

5. Child 2 Name:

Last

First

MI

Gender: (circle one) Male Female

Date of Birth: ____/____/____

Age: _____

Health Conditions (circle all that apply)

Asthma Diabetes Hyperactivity

Allergies: _____

Speech Impairment

Hearing Impairment

Medications: _____

Other Illness: (explain) _____

Vision Impaired

Ethnicity: (you must check one)

Hispanic/Latino ☐

Non-Hispanic/Non-Latino ☐

Race: (Check All that Apply): African American/Black _____

White _____

Asian _____

Alaskan Native _____

Amer. Indian _____

Native Hawaiian/Other Pacific Islander _____

Other (fill in) _____

6. Child 3 Name:

Last

First

MI

Gender: (circle one) Male Female

Date of Birth: ____/____/____

Age: _____

Health Conditions (circle all that apply)

Asthma Diabetes Hyperactivity

Allergies: _____

Speech Impairment

Hearing Impairment

Medications: _____

Other Illness: (explain) _____

Vision Impaired

Ethnicity: (you must check one)

Hispanic/Latino ☐

Non-Hispanic/Non-Latino ☐

Race: (check All that Apply): African American/Black _____

White _____

Asian _____

Alaskan Native _____

Amer. Indian _____

Native Hawaiian/Other Pacific Islander _____

Other (fill in) _____

7. Child 4 Name: _____

Gender: (circle one) Male Female

Date of Birth: _____ / _____ / _____

Age: _____

Health Conditions (circle all that apply)

Asthma Diabetes Hyperactivity

Allergies: _____

Speech Impairment Hearing Impairment

Vision Impaired

Medications: _____

Other Illness: (explain) _____

Ethnicity: (you must check one) ☐ Hispanic/Latino

☐ Non-Hispanic/Non-Latino

Race: (Check All that Apply) ☐ African American/Black
☐ Native Hawaiian/Other Pacific Islander

☐ White ☐ Asian ☐ Alaskan Native ☐ Amer. Indian
☐ Other (fill in) _____

I have filled in the required above information, and guarantee that all information, to the best of my knowledge, is correct, concerning qualifications for this program. I understand and agree that my child can and will participate in all activities, and that non-participation in any activity is grounds for immediate exclusion and/or dismissal from the program.

PARENT SIGNATURE

TODAY'S DATE

8. AUTHORIZED ESCORTS (other than parents)

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

9. EMERGENCY CONTACTS (other than parents)

Name	Home Phone	Cell Phone	Work Phone
1. _____	_____	_____	_____
2. _____	_____	_____	_____

10. FITNESS CAMP EMERGENCY MEDICAL AUTHORIZATION, ACTIVITY RELEASE AND PUBLIC RELATIONS RELEASE

PLEASE COMPLETE

Physician and/or Clinic: Name: _____ Phone Number: _____

Dentist and/or Dental Clinic: Name: _____ Phone Number: _____

Medication Policy: Columbus Recreation and Parks Department staff shall not administer medication to participants of their programs. All medication taken by participant shall be self-administered, and no participant on medication shall be registered in the program unless that person is capable of taking his/her own medications, or parent/guardian is available to administer the medication. Recreation staff may (1) Remind a participant to take medication (2) Assist participant by taking the medication from the locked storage area and hand it to the participant. **Please identify type, dosage, and time for all medication that the participant is currently taking.**

Medication: _____ Dosage: _____ Frequency: _____

Medical Authorization Policy: If attempts to contact me at the above listed phone numbers are unsuccessful, I authorize and give my consent for any emergency medical, surgical or dental treatment for my child (listed above) anywhere/anytime should it be deemed advisable by a qualified medical Doctor or Dentist, and the transportation of the child to the nearest hospital reasonably accessible. I understand this is to avoid undue delay and to assure prompt attention/treatment in an emergency. I hereby give permission to the City/CRPD to provide routine first aid care, administer prescribed medications in a life or death situation, and seek emergency medical treatment for my child when deemed necessary. In case of accident or injury, I will not hold the City of Columbus or its employees responsible. I understand and assume all risks that may occur during my child's participation in these programs. I understand that should any injury occur to my child at this camp, I will be responsible for all medical treatment and other costs through my medical insurance policy and/or personal finances.

COVID-19 Waiver: By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to, or infected by, COVID-19 by attending City of Columbus Recreation and Parks programs, and that such exposure or infection may result in personal injury, illness, permanent disability and/or death. I understand that the risk of becoming exposed to, or infected by, COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, City of Columbus employees, agents, representatives, volunteers and program participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any and all injury to my child(ren) or myself including, but not limited to, personal injury, disability, and/or death, illness, damage, loss, claim, liability, or expense of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s attendance at City of Columbus Recreation and Parks programs. On my behalf, and on behalf of my child(ren), I hereby release, covenant not to sue, discharge and hold harmless City of Columbus employees, agents and representatives, volunteers and program participants and their families of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto.

Check here to authorize the City of Columbus to use your child's photograph/video for public relations purposes.

Date ____/____/____ Parent/Guardian Signature _____