City of Gardena
Recreation and Human Services Department
1670 West 162nd Street, Gardena 90247

# OFF TRACK DAY CAMP

**A SEPARATE APPLICATION MUST BE FILLED OUT FOR EACH CHILD**
BOTH SIDES OF APLICATION MUST BE FILLED OUT COMPLETELY OR YOUR CHILD WILL NOT BE ELIGIBLE TO PARTICIPATE IN THE PROGRAM

1. _____ _____/_____/_____ MALE/FEMALE _____
YOUTH'S NAME BIRTHDATE AGE

2. _____
HOME ADDRESS APT # CITY ZIP CODE

_____
HOME PHONE E-MAIL

_____
SCHOOL GRADE

_____
SCHOOL ADDRESS CITY ZIP CODE

2. _____
MOTHER'S ANME OCCUPATION

_____
NAME OF BUSINESS E-MAIL WORK PHONE

_____
BUSINESS ADDRESS CITY ZIP CODE

3. _____
FATHER'S NAME OCCUPATION

_____
NAME OF BUSINESS E-MAIL WORK PHONE

_____
BUSINESS ADDRESS CITY ZIP

4. NUMBER OF PERSONS IMMEDIATE FAMILY: ADULTS_____ CHILDREN_____

5. IN AN EMERGENCY, IF PARENT/GUARDIAN CANNOT BE CONTACTED, PLEASE NOTIFY:

_____
NAME RELATIONSHIP PHONE #

_____
NAME RELATIONSHIP PHONE #

6. PERSONAL PHYSICIAN (complete information must be filled in):

_____
NAME PHONE #

_____
ADDRESS CITY ZIP CODE

## Parent/Legal Guardian Consent for Emergency Medical Treatment

In the even of injury and I cannot be reached, or tie does not permit, I give permission to the City of Gardena Recreation and Human Services Department staff to obtain emergency medical treatment required for the immediate care of my child.

It is further understood that such permission includes the administration of medicine or treatment ordered by a duly licensed medical doctor. In no event will the City of Gardena or the City of Gardena Recreation and Human Services Department staff beheld liable for any accident or any emergency medical treatment pursuant to this consent.

7. _____
SIGNATURE OF MOTHER/GUARDIAN DATE

8. _____
SIGNATURE OF FATHER/GUARDIAN DATE

9. **NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FCILITY**: (Participants will not be permitted to leave with any person without written authorization from parent or guardian.)

NAME RELATIONSHIP PHONE

_____MOTHER/GUARDIAN_____

_____MOTHER/GUARDIAN_____

_____

_____

_____

10. IS THERE ANYONE WHO **MAY NOT** PICK UP YOUR CHILD?
NAME_____RELATIONSHIP_____
NAME_____RELATIONSHIP_____

11. **PLEASE LIST ANY ILLNESSES OR ALLERGIES YOUR CHILD HAS. ALSO, PLEASE LIST ANY MEDICAITON YOUR CHILD TAKES ON A REGULAR BASIS:** (No medical equipment, IV prescriptions, respirators, etc. for use by participants will be permitted at the facility.)

A. **Illness, Allergy, or Other:** _____
Name of Medication taken: _____Time administered: _____

B. **Illness, Allergy, or Other:** _____
Name of Medication taken: _____Time administered: _____

12. I have read the POLICIES OF THE AFTER SCHOOL PROGRAM. If any of the stated regulations should be violated, I understand that program personnel have the authority to restrict or dismiss participants from activities and/or programs.

_____
SIGNATURE OF MOTHER/GUARDIAN DATE

13. WHAT WEEKS WILL YOUR CHILD BE ATTENDING OFF TRACK DAY CAMP?

Beginning Week:_____ Ending Week: _____