ROSELLE PARK DISTRICT

Participant Information Form
Summer 2020 & School Year 2020-21

Participant's Name: ____ Birth Date: ___________________________

Program Name: ____ Date(s): ______________________________

School Attending 2020-21 School Year: ______________________________ Grade for 2020-21 School Year: ___________

Participant's Address: ____ Phone: _____________________________

City, State, Postal Code: ____ Gender: Male Female

Doctor's Name: ____ Phone: _____________________________

List the Parent/Guardian names in the order you wish to be contacted in the event of an emergency.

Name: ______________________________ Relationship: _____________ Cell Phone: _______________________

Name: ______________________________ Relationship: _____________ Cell Phone: _______________________

Preferred Email for Park District Communication (Required)____

Additional Emergency Contacts and individuals authorized to pick up the participant.
(List three names not including the parents/guardians listed above.)

	Name	Relationship to Participant	Phone
1.	___________________________________	_____________________________	____________________________
2.	___________________________________	_____________________________	____________________________
3.	___________________________________	_____________________________	____________________________

Describe any ***current*** health condition (e.g., food allergies, asthma) requiring medication, treatments, special restrictions or considerations during program hours. (**Note: Additional forms may need to be completed.**; e.g., Allergy Action Plans must be completed for food allergies.)

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Describe any other information (e.g., general temperament, legal considerations) about your child that our staff should know.

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Does your child need any reasonable accommodation (e.g., additional assistance, program adaptations or a 1:1 companion provided by WDSRA), in accordance with the Americans with Disabilities Act, to fully participate in the program? Y N
If yes, please explain:

____

Does your child take medication during program hours? Y* N
***Complete a Medication Information form and a Permission to Dispense/Administer Medication and Waiver and Release of All Claims form.**

I have completed the Participant Information Form to the best of my ability. In the event of an emergency and that parents or a designated responsible adult cannot be reached, I authorize the Roselle Park District to send my child (properly accompanied) to the nearest hospital facility for emergency medical treatment.

Signature of Parent or Guardian ____ **Date** ___________________________

If you have any questions or need further assistance, please reach out to the District's ADA Compliance Officer or the Superintendent of Recreation at (630) 894-4200