



CHILD'S INFORMATION:

NAME: _____ BIRTH DATE: _____ AGE: ____
ADDRESS: _____ CITY: _____ STATE: __ ZIP: ____
BAPTISMAL SAINT: _____ NAME DAY: _____

PARENT 1 INFORMATION:

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ CITY: _____ STATE: __ ZIP: ____
CELL PHONE: _____ WORK: _____
EMPLOYER: _____ BUSINESS ADDRESS: _____
EMAIL ADDRESS: _____

PARENT 2 INFORMATION:

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ CITY: _____ STATE: __ ZIP: ____
CELL PHONE: _____ WORK: _____
EMPLOYER: _____ BUSINESS ADDRESS: _____
EMAIL ADDRESS: _____

EMERGENCY CONTACT (OTHER THAN PARENTS)

PERMISSION TO DROP OFF AND PICK UP MY CHILD FROM AGAPE CAMP:

NAME: _____ RELATIONSHIP: _____
CELL PHONE: _____

NAME: _____ RELATIONSHIP: _____
CELL PHONE: _____

Does your child have ALLERGIES?

_____ **NO**

_____ **YES, PLEASE COMPLETE THE MEDICAL RELEASE FORM**

MEDICATION CONSENT FORM

AGAPE SUMMER CAMP STAFF will not dispense medication to a minor child or other participant until the Permission and Waiver to Dispense Medication and Medication Information Form has been fully completed by a parent or guardian. AGAPE's procedures for dispensing medication are available for review.

NAME OF PROGRAM _____ DATE _____

I, _____, permit the staff of the AGAPE SUMMER CAMP to administer the following medication to my child:

(Name of medication)

I understand that it is my responsibility to give the medication directly to the program staff in the original prescription container(s), clearly labeled with the following information:

CAMPER'S NAME: _____

Name of medication and complete dosage instructions:

In all cases, the recommended dosage of any medication will not be exceeded. If, after administering medication, there is an adverse reaction, I permit the AGAPE SUMMER CAMP to secure any treatment deemed necessary for immediate care from any licensed hospital physician and/or medical personnel. I agree to be responsible for payment of all medical services rendered.

SIGNATURE OF PARENT 1: _____

SIGNATURE OF PARENT 2: _____

WAIVER & RELEASE OF ALL CLAIMS

I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medication to my minor child. Such risks include but are not limited to, failing to properly administer the medication, failing to observe side effects, failing to assess and/or recognize an adverse reaction, failing to assess and/or recognize a medical emergency, and failing to recognize the need to summon emergency medical services.

In consideration of the AGAPE Preschool administering medication to my minor child, I do hereby fully release or discharge the AGAPE Preschool and its officers, agents, volunteers, and employees from any and all claims from injuries, damages, and losses I or my minor child may have (or accrue to me or my minor child), and arising out of, connected with, incidental to, or in any way associated with the administering of medication.

If submitting this form online or via fax, my online or facsimile signature shall substitute for and have the same legal effect as an original signature.

Signature of Parent/Legal Guardian _____

Date _____

MEDICATION DISPENSING INFORMATION

BACKGROUND INFORMATION

CAMPER'S NAME: _____ Age _____

PARENT'S NAME: _____

CELL PHONE: _____

DOCTOR'S NAME: _____

DOCTOR'S PHONE: _____

MEDICATION INFORMATION

NAME OF MEDICATION _____

DOSE: _____

TIME OF DOSE: _____

SIDE EFFECTS: _____

OTHER INFORMATION: _____

I understand that it is my responsibility to give the medication directly to program staff with full instructions in individual dosage containers, clearly labeled envelopes, or in original prescription bottles.

In all cases, medication dispensing can only be changed or modified by completing another Permission and Waiver to Dispense Medication Form and Medication Information Form.

I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, guardian, ward, or other family member is accurate. I also understand that it is my responsibility to inform AGAPE SUMMER CAMP if any changes in the dispensing of medication occur.

If submitting this form online or via fax, my online or facsimile signature shall substitute for and have the same legal effect as an original signature.

Signature of Parent/Legal Guardian _____

Date _____