Crawford Park District's
Forest Friends Program Registration

Child's name _____ Age _____ Birth date _____

Child's address _____

City, State, Zip _____

Preferred session: ☐ morning (9-11:30am) ☐ afternoon (1-3:30pm) ☐ either one

Contact information, emergency or otherwise. Please number 1 to 4, one being the first person to call.

__ Mother's name _____ Phone # _____

__ Father's name _____ Phone # _____

__ Other _____ Phone # _____

__ Other _____ Phone # _____

Person(s) authorized to pick up child _____

Email address for class communication _____

Facts concerning the child's medical history including allergies, medications being taken, and any impairments to which a physician should be alerted.

Allergies _____

Medications _____

Physical impairments _____

Dietary restrictions _____

Other pertinent information _____

Crawford Park District employees will not dispense over-the-counter or prescription medications to participants.

PHOTOGRAPH PERMISSION

I give permission for the Crawford Park District to use photographs/videos taken of my child at the park for promotional purposes including, but not limited to, news releases, newsletters, and the Park's social media.

Parent/Guardian signature _____

Program sessions will be held on Mondays, Wednesdays, and Fridays beginning September 9th and ending April 30th. Cost is $100/month. Payment for the first month must be received in order to confirm your child's registration. Registration begins Wednesday, August 26th at Lowe-Volk Nature Center. Please bring these completed forms and payment to register your child.

PARENTAL WAIVER, CONSENT AND RELEASE FORM

The undersigned, in my capacity as parent and/or legal guardian of _____(child), hereby provides consent for my child to participate in the Roots & Shoots program at the Crawford Park District. I understand participation in this activity is inherently dangerous and that injuries are possible.
I agree to hold harmless and indemnify the Crawford Park District from any and all liability including, but not limited to, liability for any injuries or damages sustained by _____(child) as a result of participating in the Roots & Shoots program.

Signature of Parent/Guardian _____

Date _____

EMERGENCY MEDICAL TREATMENT CONSENT OR REFUSAL
PART 1 OR 2 MUST BE COMPLETED

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under Crawford Park District authority, when parents or guardians cannot be reached.

PART 1: To Grant Consent

I hereby give consent for the following medical care providers and local hospital to be called:
Doctor _____
Phone # _____
Dentist _____
Phone # _____
Medical Specialist _____
Phone # _____
Hospital _____
Phone # _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above named Doctor, 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 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 prior to the performance of such surgery.

Signature of Parent/Guardian _____

Date _____

PART 2: Refusal to Consent

I do not give my consent for emergency medical treatment; I wish the Crawford Park District would take the following action:

_____

Signature of Parent/Guardian _____

Date _____