

RECREATION STATION 2010 REGISTRATION PACKET

Dear Parent/Guardian,

The following registration packet must be completed before enrollment will be accepted. Recreation Station registration is on a first come first serve basis. Payment for all 9 weeks or for each week you want your child to attend is the only method that guarantees enrollment. If you wait to enroll your child at the end of each week you risk the program being full and there not being room for your child. **No refunds will be given for missed weeks or days.**

There is a payment plan option for those enrolling a child in all 9 weeks and are not able to pay the full fee up front. The payment plan process is listed below. **If your child is on the payment plan and he/she misses a week of camp you are still required to make a payment for that week.**

June 2, 3, and 4 are optional days. They are not included as part of the payment plan package. You must enroll for these days separately.

If you enroll your child in all 9 weeks of camp your child will receive a **free** Rock River Rapids season pass.

If you have any questions regarding Recreation Station or the enrollment process please call the Derby Recreation Center at 788-3781.

Sincerely,

Dee Anna Claytor
Program Supervisor

Recreation Station Payment Plan (MUST BE ENROLLING IN ALL 9-WEEKS UPFRONT TO BE ELIGIBLE FOR THIS PAYMENT PLAN)

I. Qualifications

1. Must be enrolling in all 9-weeks to be eligible for the payment plan.
2. Must pay first week up front in order to qualify for payment plan.
3. Payment is by credit or debit card only.

II. Payment Plan Process

1. Must sign commitment letter and return to support staff.
2. Credit or debit cards will be charged each Monday.
3. Camper will be unenrolled in program if payment is declined.

DRC RECREATION STATION REGISTRATION 2010

***NO CHILD WILL BE ENROLLED WITH INCOMPLETE RECORDS**
All necessary forms are included. FORMS MUST BE COMPLETED
WITH PROPER SIGNATURES before enrollment will be accepted.

CAMPER INFORMATION

Shirt Size _____

Name _____ Birthdate _____ Grade Completed _____ Sex _____

Address _____ City _____ Zip _____

Does child take medication? Yes No

If yes, the enclosed medication self-administration form must be completed. Doctor's signature is required.

Does child know how to swim? Yes No

Do you give permission for your child to watch a PG rated movie? Yes No

Please list any **health conditions** or **allergies** your child might have:

PARENT/GUARDIAN INFORMATION

First Parent/Guardian Name _____

Address (if different from camper's) _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Marital Status/Custody Arrangements _____

Second Parent/Guardian Name _____

Address (if different from camper's) _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

EMERGENCY CONTACT INFORMATION (other than parents)

Name #1 _____ Relationship _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

SACK LUNCH NEEDED MONDAY-FRIDAY
PLEASE CIRCLE THE WEEK(S) YOUR CHILD WILL ATTEND

****June 2-4 are additional days that are not included in the payment plan.**
These days must be paid for individually.**

June 2-4 All Aboard (optional)

July 5-9 Surf's Up

June 7-11 Sports Center

July 12-16 Defying Gravity

June 14-18 Walk on the Wild Side

July 19-23 Goin' Green

June 21-25 Global Getaways

July 26-30 Mission Impossible

June 28-July 2 Party in the USA!

August 2-6 Wild and Crazy Kids

Days Attending _____
(Example: M-F)

Hours Attending _____
(Example: 8:30am-5:30pm)

RECREATION STATION TRANSPORTATION OPTIONS

Mark only one

**Children need to be at the bus stop five minutes before pick-up time.
Pick-up time is stated first, then drop off time. The bus will not wait for late arrivals.
Children will sign themselves in and out upon entering and departing the bus.**

_____ Parent/Guardian will pick up and drop off at the Derby Recreation Center.

_____ Camper will walk/ride bicycle.

What time do you give permission for your child to check him/herself out?
(camp ends at 5:30pm)_____

_____ Ride bus from Derby Hills Elementary (west parking lot); 7:45am, 5:40pm

_____ Ride bus from El Paso Elementary (west parking lot); 7:55am, 5:50pm

_____ Ride bus from Tanglewood Elementary (south parking lot); 8:05am, 6:00pm

_____ Ride bus from Hand Park (first shelter); 8:15am, 6:10pm

_____ Ride bus from Garrett Park (parking lot); 8:25am, 6:20pm

**Registration forms will only be accepted at the Derby Recreation Center, 801 E. Market
Monday-Thursday, 5:30am-9:00pm and Friday, 5:30am-7:00pm
MUST REGISTER BY 7:00PM THE FRIDAY PRIOR TO ATTENDING. SPACE IS LIMITED.**

WAIVER FOR PARTICIPATION

1. I/We the below signed person/parent(s) having legal custody/legal guardianship of said minor, give permission for said minor to attend any DRC activities supervised by authorized DRC staff. Said minor is physically able and mentally prepared to participate in all activities.
2. I/We do hereby authorize the DRC and DRC staff to transport said minor in DRC bus, van, car or other vehicle to/from the site for daily transportation and/or field trips, emergency care, etc.
3. I/We have read the Parent Handbook and understand all policies and procedures set forth by the DRC. I/We shall abide by said policies/procedures and will review these with my/our child. I/We support the DRC in its enforcement of these policies/procedures.
4. I/We have read and understand the DRC's policies concerning discipline and will pass this information along to my/our child. I/We understand that the DRC reserves the right to dismiss any child who fails to adhere to DRC Recreation Station rules and regulations.
5. I/We understand fully and will abide by the DRC's policy concerning drop-off and pick-up of children. I/We shall be prepared DAILY to present photo ID to on-site staff to determine my/our identity as authorized persons to pick up my/our child. Further, I/We shall inform others who are authorized to call for our child to present photo ID when picking up my/our child.
6. In consideration of the DRC accepting this entry, I/We hereby for myself, my/our child, my heirs, executors and administrators, waiver and release any and all rights and claims for damages my/our child may have against the Derby Recreation Commission, City of Derby, or USD No. 260, and its representatives, successors and assigns for any and all injuries suffered by my child at any activities sponsored by these groups. Parent or Legal Guardian must sign for any child under 18 entering the program.

Parent/Guardian Signature _____ Date _____



HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d)(1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

Complete one form for each child or youth attending the School Age Program.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)
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First and Last Name of the Child's or Youth's Mother or Guardian

Mother/Guardian's Home Street Address	City	Zip Code +4	Home Phone # ()
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Mother/Guardian's Work Place Name & Street Address	City	Zip Code +4	Work Phone # ()
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First and Last Name of the Child's or Youth's Father or Guardian

Father/Guardian's Home Street Address	City	Zip Code +4	Home Phone # ()
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Father/Guardian's Work Place Name & Street Address	City	Zip Code +4	Work Phone # ()
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Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)
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Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.	City	Zip Code +4	Phone # during program hours:
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First and Last Name of Physician & Street Address	City	Zip Code +4	Phone Number ()
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Name of Hospital Preference in case of emergency.
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Yes	No	N/A	Complete the following information about medications for this child or youth.
		X	Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
			If yes above, is there signed permission on file?

Circle any of the following conditions or difficulties that affect this child or youth.			
Allergies	Frequent sore throats/ colds	Ear Infections or Aches	Heart or Lung Conditions
Skin Problems	Asthma	Headaches	Diabetes
Vision	Speech/Communication	Hearing	Emotion/Behavior
Other: Please describe.			

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.)

Complete the following information about this child's or youth's immunization status.

Yes	No	
		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
		If yes, are this child's or youth's immunizations current?
X	X	If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
DPT, DT*, TD (*DT only if child is allergic to DTP)		/ /	/ /	/ /	/ /	/ /
POLIO		/ /	/ /	/ /	/ /	
MMR		/ /	/ /			
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
HIB (Hemophilus Infl. B) *RECOMMENDED		/ /	/ /	/ /	/ /	
HBV (Hepatitis B Vaccine) *RECOMMENDED		/ /	/ /	/ /		
VAR (Varicella-Chicken Pox) *RECOMMENDED		/ /				

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed
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If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?
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I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form	Date Signed
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RECREATION STATION AUTHORIZATION TO PICK UP CHILD

Participant's Name: _____

Please list all persons authorized to pick up the child or to notify in case of emergency. Please include the names of the PARENTS who are authorized to pick up the child. No one will be allowed to pick up the child unless they are on this form. Photo ID will be required at the time of pick up-we make no apologies for safeguarding your child. Children must be signed out by the person picking up the child. Thank you for your cooperation!

Name: _____ Relation to child: _____

Street Address: _____ City: _____ Zip: _____

Home Phone: _____ Business Phone: _____ ext. _____

Cell: _____

Name: _____ Relation to child: _____

Street Address: _____ City: _____ Zip: _____

Home Phone: _____ Business Phone: _____ ext. _____

Cell: _____

Name: _____ Relation to child: _____

Street Address: _____ City: _____ Zip: _____

Home Phone: _____ Business Phone: _____ ext. _____

Cell: _____

Name: _____ Relation to child: _____

Street Address: _____ City: _____ Zip: _____

Home Phone: _____ Business Phone: _____ ext. _____

Cell: _____



PARENTAL PERMISSION FORM FOR OFF-PREMISE TRIPS

Name of the facility exactly as stated on the license or certificate Derby Recreation Center			License/Certificate # 52178		
Street Address of the Facility 801 E. Market		City Derby	Zip Code + 4 67037-0324	County Sedgwick	

_____ may go to the following locations off the premises **with** adult supervision: First and Last Name of Child or Youth

Place Derby Bowl	Street Address 444 S. Baltimore	City Derby	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place Derby Middle School	Street Address 801 E. Madison	City Derby	By Vehicle X	Walk X
Signature of Parent or Guardian			Date Signed	

Place Derby Plaza Theaters	Street Address 1300 N. Nelson Drive	City Derby	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place El Paso Elementary	Street Address 900 E. Crestway	City Derby	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place English Park	Street Address Westview & Crestway	City Derby	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place Garrett Park	Street Address Chet Smith & Sharon Dr.	City Derby	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place Great Plains Nature Center	Street Address 6232 E. 29 th St. North	City Wichita	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place Hand Park	Street Address Lakeview & English	City Derby	By Vehicle X	Walk X
Signature of Parent or Guardian			Date Signed	

Place High Park	Street Address 2700 E. Madison	City Derby	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place Riley Park	Street Address Willow & Kay Street	City Derby	By Vehicle X	Walk X
Signature of Parent or Guardian			Date Signed	

Place Riverside Park	Street Address 720 Nims	City Wichita	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place Rock River Rapids	Street Address 1900 E. James Street	City Derby	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place Sedgwick County Zoo	Street Address 5555 Zoo Boulevard	City Wichita	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place Swaney Elementary	Street Address 501 English	City Derby	By Vehicle X	Walk X
Signature of Parent or Guardian			Date Signed	

Place Tanglewood Elementary	Street Address 830 Ridgecrest Road	City Derby	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place Derby Hills Elementary	Street Address 230 N. Woodlawn	City Derby	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place Derby High School	Street Address 920 N. Rock Road	City Derby	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place Osage Park	Street Address 2121 W. 31st St.	City Wichita	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place Sedgwick County Park	Street Address 6501 W. 21st North	City Wichita	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place Great Plains Transportation Museum	Street Address 700 E. Douglas Ave.	City Wichita	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place Mid-America All Indian Center	Street Address 650 N. Seneca	City Wichita	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

Place Water Center	Street Address 101 E. Pawnee St.	City Wichita	By Vehicle X	Walk
Signature of Parent or Guardian			Date Signed	

FOR SCHOOL AGE CHILDREN OR YOUTH ONLY:

I hereby authorize my **school age child** _____
First and Last Name of Child or Youth
Birth Date MM/DD/YYYY

to walk to and from the following location(s) **without** adult supervision:

Place	Street Address	City	By Vehicle	Walk
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk
Signature of Parent or Guardian			Date Signed	

**Derby Recreation Center
Recreation Station
Swimming/Water Activity Waiver**

Participants may participate in swimming and water activities. Reasonable precautions will be taken to provide for the participants' safety. Participants will use the pools and participate in water activities between the dates of June 2, 2010 and August 6, 2010.

I request that _____ be allowed to swim and participate in water activities as stated above and I relieve and absolve the Derby Recreation Commission of any responsibility other than that stated above.

I understand that if I do not want my child to swim or participate in water activities on any given day I must provide written notice to my child's camp leader.

Parent/Guardian Signature

Date

**Derby Recreation Center
Recreation Station
Personal Items/Dress Code Policy**

1. The Derby Recreation Commission asks that campers do not bring personal items (i.e. cell phones, portable game systems, mp3 players) to camp unless it is listed on the weekly newsletter. If campers do bring personal items to camp the Derby Recreation Commission and Recreation Station staff are not responsible for lost, stolen, or broken items.
2. Recreation Station has the following dress code policy in place:
 - Daily-Please have your child wear sturdy shoes, socks, and comfortable clothing. NO OPEN-TOED SHOES.
 - Please apply sunscreen to your child daily. Staff will remind children to reapply sunscreen before going swimming outdoors and before a long outdoor trip.
 - Weather appropriate clothing.
 - Recreation Station shirt for field trips other than swimming.
 - Label your child's clothing, swimsuits, hats, etc.
 - Swimming-Please have your child outfitted in a swimsuit, towel, sunscreen and shoes.
 - Short shorts and bare midriffs are not allowed.
 - Other clothing items may be deemed inappropriate at recreation staff's discretion.

By signing below you acknowledge you that have read, understand, and agree with the personal item and dress code policy.

Parent/Guardian Signature

Date



AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A) except School Age Programs reference K.A.R. 28-4-582(e)(2)(B).

Name of facility exactly as stated on the license/certificate. Derby Recreation Center	License or Certificate # 52178
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I hereby authorize Derby Recreation Center Staff (Name of individual/staff member) and/or Recreation Station Staff (Name of individual/staff member) who is (are) representative(s) of the above named facility to give consent for any and all necessary emergency medical care for my child or youth _____ (First and Last Name of Child or Youth) while said child or youth is in said facility's custody between the dates of _____ and _____.
MM/DD/YYYY MM/DD/YYYY

Signature of Parent or Guardian	Date Signed
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Witness to Parent's or Guardian's signature only if required by the local hospital or clinic.	Date Signed
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Notarization of Parent's or Guardian's signature only if required by local hospital or clinic.

State of Kansas
County of _____
Signed or attested before me on _____ by _____.
MM/DD/YYYY Name of Person

(Seal, if any)

Signature of notarial officer

Title and Rank

My appointment expires: _____

Complete information regarding health care insurance, if applicable

Health Insurance Policy Name _____ Policy number _____
Medial Assistance Program _____ Card Number _____
Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation: _____
List any know allergies or other information about the medical status of this child or youth pertinent in case of emergency:

THE MEDICAL RECORD/ASSESSMENT FORM (OR HEATH STATUS HISTORY FORM FOR SCHOOL AGE PROGRAMS) AND THE AUTHORIZATION FOR EMERGENCY MEDICAL CARE MUST BE TAKEN TO THE EMERGENCY ROOM. BOTH FORMS MUST ALSO BE IN A VEHICLE WHEN THE CHILD OR YOUTH IS TRANSPORTED BY THE FACILITY.



Authorization for Self-Administration of Medication to Children and Youth SCHOOL AGE PROGRAMS

According to K.A.R. 28-4-590(e)(5)(A) any operator may permit a child or youth with a **chronic illness, condition requiring prescription medication on a regular basis, or a condition requiring the use of an inhaler** to administer the medication under staff supervision. The operator shall obtain written permission for the child or youth to self-administer medication from the child's or youth's parent or other adult responsible for the child or youth, and from the licensed physician or nurse practitioner treating the condition of the child or youth. Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. A record of administration must be kept.

First and Last Name of Child or Youth			
Name of Medication (only one medication per authorization)			
Reason for Medication			
Dose	Time to be Given	Start Date	Stop Date**
Print the Name of Licensed Physician or Nurse Practitioner prescribing the medication		Phone # of Health Care Provider	
I allow the self-administration of the above medication by my child or youth under staff supervision.			
Signature of Parent or Responsible Adult			Date Signed
I authorize the self-administration of the above medication by the child or youth listed above under staff supervision.			
Licensed Physician or Nurse Practitioner Signature			Date Signed

****Stop date not to exceed one year from the start date. A new authorization is to be completed any time the medication, dosage, times to be given, or instructions from the parent or health care provider change from the information included on this form. Additional copies of this form may be attached to this page if more space is needed to record the administration of the medication for up to one year if there are no changes in instructions. Above information must be completed on each page but the parent's signature and the licensed physician or nurse practitioner signature is required only once per year.**

THIS FORM IS TO BE USED TO DOCUMENT SELF ADMINISTRATION OF ONLY THE MEDICATION IDENTIFIED ABOVE. Provider or staff member supervising the self-administration of medication to note any comments or remarks about the child's or youth's appearance and/or condition on the back of the form.

Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.

