A "NOT SO BUMMER SUMMER #3" 2023

REGISTRATION FORM

Fill out and RETURN to HTS Summer Program

A $50 REGISTRATION FEE IS REQUIRED FOR EACH FAMILY. PAYMENT FOR THE SUMMER PROGRAM ($1,650) IS DUE ON OR BEFORE JUNE 1ST VIA FACTS.

PARTICIPANT(S) INFORMATION

CHILD NAME (1): _____(Nickname) _____
Grade entering in Fall '22 _____ SCHOOL _____
T-SHIRT SIZE: (Circle) YOUTH: YXS – YS – YM – YL – YXL ADULT: S – M – L – XL

CHILD NAME (2): _____(Nickname) _____
Grade entering in Fall '22 _____ SCHOOL _____
T-SHIRT SIZE: (Circle) YOUTH: YXS – YS – YM – YL – YXL ADULT: S – M – L – XL

CHILD NAME (3): _____(Nickname) _____
Grade entering in Fall '22 _____ SCHOOL _____
T-SHIRT SIZE: (Circle) YOUTH: YXS – YS – YM – YL – YXL ADULT: S – M – L – XL

PRIMARY PARENT/GUARDIAN (1):_____ Relationship to Child(ren)_____
ADDRESS: _____CITY _____ZIP CODE _____
Home Phone _____Cell Phone _____ Work Phone _____
EMAIL ADDRESS _____

PARENT/GUARDIAN (2): _____ Relationship to Child(ren)_____
ADDRESS: _____CITY _____ZIP CODE _____
Home Phone _____Cell Phone _____ Work Phone _____
EMAIL ADDRESS _____

EMERGENCY CONTACT *(other than parent/guardians)*
Name: _____
Relationship to Child(ren): _____
Phone: _____

THE FOLLOWING PEOPLE ARE AUTHORIZED TO PICK UP MY CHILD(REN) FROM HTS SUMMER PROGRAM 2021:

(other than the parent/guardian)

1. _____ *(Relationship)* _____
2. _____ *(Relationship)* _____
3. _____ *(Relationship)* _____

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Please put your **INITIALS** if you agree with the following:

_____ *I agree that ALL of REGISTRATION FORM (pg.1) and the above REGISTRATION FORM (pg. 2) has been completed to the best of my knowledge.*

_____ *I agree for my Child(ren) to be photographed during the Summer Program, which may appear on school social media.*

_____ *I agree to inform the summer program immediately if any of the above information changes throughout the summer.*

_____ *I understand that in the event my child is not picked up on time I will be charged an additional $10 late fee for every 10 minutes my child(ren) is picked up AFTER 3:00pm.*

PARENT/GUARDIAN (Print Name)_____

Signature: _____**Date**_____

HEALTH HISTORY PROFILE

*Fill out **ONE PER CHILD** and RETURN to HTS Summer Program 2023*

*THIS MUST BE COMPLETED FOR **EACH CHILD:***

PARTICIPANTS INFORMATION

CHILD NAME: *(Last, First, Initial)*	DATE OF BIRTH:	AGE:

PARTICIPANTS INSURANCE INFORMATION

CARRIER:	ID NUMBER:	GROUP NUMBER:
MEMBER SERVICES PHONE NUMBER:	*I accept full responsibility for the costs of any medical care/treatment I have hereby authorized.*	
LICENSED PHYSICIAN NAME:		PHONE:

PARTICIPANTS HEALTH HISTORY *(Circle ALL that apply)*

DISEASES	ALLERGIES	CHRONIC OR RECURRING ILLNESSES	CHRONIC OR RECURRING ILLNESSES contin...	IMPAIRMENTS
+ Kidney + Lyme + Mumps + Measles + Tuberculosis + Chicken Pox + Rheumatic Fever + Other _____	+ Animals + Food * + Hay Fever + Insect Stings * + Plants + Pollen + Medicine/Drugs _____ + Other_____ ** If yes, epipen must be provided*	+ Seizures + Asthma + Arthritis + Sinusitis + Diabetes + Hypertension + Ear Infections	+ Heart Defect/Disease + Bleeding Disorders + Musculoskeletal Disorders + Frequent Headaches + Other _____	+ Speech + Hearing + Sights + Physical + Other _____

Does the participant carry an epipen? + YES + NO

Does the participant carry an inhaler? + YES + NO **Can participant self-administer inhaler?** + YES + NO

RESTRICTIONS *(Please circle ALL that apply for the following restrictions)*

Does not eat: + Red meat + Pork + Poultry + Seafood + Dairy Products + Eggs + Peanuts + Wheat + Gluten + Other

Explain any restrictions to food or activity:

GENERAL QUESTIONS *(Please circle all that apply – Explain "yes" answers below)*

Has/does the participant:	YES	NO
1. Had recent injury, illness, or infectious disease?	+	+
2. Ever had a head injury?	+	+
3. Wear glasses, contacts or protective eyewear?	+	+
4. Ever passed out during exercise?	+	+
5. Ever had emotional difficulties for which professional help was sought?	+	+
6. Have frequent / or prone to nosebleeds?	+	+
7. Have any skin problems? (itching, rashing)	+	+
8. Have severe menstrual cramps?	+	+

Has/does the participant:	YES	NO
9. Any orthodontic supplies being brought to the program?	+	+
10. Take any PRESCRIPTION MEDICATION?	+	+

If you answered "YES" to any of these questions please provide the question number. Attach additional information if needed

_____
_____
_____
_____
_____
_____

I agree that the HEALTH HISTORY FORM (pg.3) and the above information has been completed to the best of my knowledge and assume responsibility for the health of my child.

PARENT/GUARDIAN (Print)_____

Signature: _____**Date**_____

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MEDICAL MATTER:

Please put your **INITIALS** if you agree with the following:

_____ *I hereby warrant that to the best of my knowledge, my child(ren) is in good health, and I assume responsibility for the health of my child(ren), and for the cost and expense of any medical treatment should such become necessary while my child is participating in the above named events.*

_____ *I hereby give my consent, to HTS staff and/or a currently certified first aider to give necessary first aid/CPR to my child.*

_____ *I hereby give my consent, to the person in charge at HTS to obtain and consent to, on my behalf, whatever medical diagnosis treatment is deemed necessary or advisable by such person for the well-being of my child.*

_____ *I hereby give consent, in the event of injury or illness, for emergency medical treatment, hospitalization or other medical treatment as may be necessary for the welfare of my child by a physician, qualified nurse and/or hospital or health care facility while my child is participating in the above names events.*

_____ *Further, I hereby release and discharge Holy Trinity employees, chaperones, volunteers from any and all liability arising out of such medical treatment.*

MEDICATION: *If your child needs medication administered WHILE attending the summer program we need the medication BEFORE he or she can start the program. ALL MEDICATIONS need to be in their ORIGINAL BOXES. The **MEDICAL AUTHORIZATION FORM** must be CURRENT and match the MEDICATION prescribed specifically. ALL OTC medications need to be in NEW and unopened packages.*

PARENT/GUARDIAN (Print)_____

Signature: _____**Date**_____