

**Columbus Recreation and Parks Department  
Participant Waiver Form**

**I. PARTICIPANT INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Circle One: M F Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Current Grade: \_\_\_\_\_  
Mother/Guardian Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell /Pager: \_\_\_\_\_  
Father/Guardian Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell /Pager: \_\_\_\_\_

**II. EMERGENCY CONTACT INFORMATION**

If parents or guardians are unable to be reached, contact:

Name: _____	Name: _____
Day Phone: _____	Day Phone: _____
Relationship to Participant: _____	Relationship to Participant: _____

**III. MEDICAL INFORMATION**

**Physician and/or Clinic**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Dentist and/or Dental Clinic**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please provide specific information for any **medical or behavioral** conditions in which staff should be aware in order to provide a safe and successful environment (allergies, activity restrictions, asthma, ADHD etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication Policy:** Columbus Recreation and Parks Department staff shall not administer medication to participants of their programs. All medication taken by participant shall be self administered, and no participant on medication shall be registered in the program unless that person is capable of taking his/her own medications, or parent/guardian is available to administer the medication. Recreation staff may (1) Remind a participant to take medication (2) Assist participant by taking the medication from the locked storage area and hand it to the participant.

**Please identify type, dosage, and time for all medication participant is currently taking.**

**Medication:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

**IV. PARTICIPANT/PARENT/GUARDIAN RELEASE**

\_\_\_\_\_ has my permission to participate in all activities offered during the camp. If attempts to contact me at the above listed phone #'s are unsuccessful. I authorize and give my consent for any emergency medical, surgical or dental treatment for my child (listed above) anywhere/anytime should it be deemed advisable by a qualified medical Doctor or Dentist, and the transportation of the child to the nearest hospital reasonably accessible. I understand this is to avoid undue delay and to assure prompt attention/treatment in an emergency. I authorize the City of Columbus to take all necessary steps to insure my child's health & safety in case of an emergency and to administer any needed medications. In case of accident or injury I will not hold the City of Columbus, or its employees responsible. I understand and assume all risks that may occur during my child's participation in these programs. I understand that should any injury occur to my child at this camp, I will be responsible for all medical treatment and other costs through my medical insurance policy and/or personal finances.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
(parent or legal guardian)