

**REGISTRATION**  
**Town of Vienna SUMMER RECREATION PROGRAM**  
**Kindergarten through age 14 residents**

**JULY 2 – AUGUST 10**

CHILD'S NAME: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_

Last

First

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ (Check if Unlisted) \_\_\_\_\_ DAYTIME PHONE: \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT:**

NAME: \_\_\_\_\_

Last

First

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ (Check if Unlisted) \_\_\_\_\_

**PERMISSION FOR ACTIVITIES**

I/We, the parents/guardians of the student named below, understand the nature of the Town of Vienna Summer Recreation Program and we are in accord with the purposes of and procedures governing the program. We hereby grant permission for our son/daughter to participate.

We understand that adequate and appropriate supervision will be provided. We recognize, however, that unanticipated situations and problems can arise which are not reasonably within the control of the staff (including volunteers).

We further agree to release and hold harmless the Town of Vienna Summer Recreation Program, their agents, officers, employees, and volunteers, from any and all liability, claims, suits, demands, judgments, costs, interest and expense (including attorneys' fees and costs) arising from such activities, including any accident or injury to the student and the costs of medical services.

**EMERGENCY MEDICAL**

In the event of an injury requiring medical attention, I hereby grant permission to the staff (including g volunteers) to attend to my son/daughter. If the injury warrants further medical attention, I expect every effort will be made to contact me to receive my specific authorization before action is taken. If efforts to contact me are unsuccessful, I grant permission for necessary medical treatment to be given. In addition, I hereby give my permission to the staff (including volunteers) to take my child to the physician, dentist, or to the hospital if an accident or serious illness occurs during the program activities and I cannot be located.

**ADDITIONAL INFORMATION (Please identify any medical concerns and/or allergies)**

Allergies: food, insect etc.

Required medications: \_\_\_\_\_

If my child requires medication, I understand that I am obligated to ensure that the medication and proper instructions are provides.

If my child requires the use of an epipen for allergic reactions, I understand that one must one must be provided for all field trips.

Other information we need to be aware of: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Return forms by June 25<sup>th</sup>, 2012 to Town of Vienna Town Clerks Office or mail to Vienna Town Clerk, POBox 250, North Bay, NY 13123. After that we will still accept applicants on the first day they attend the program. This helps with knowing an approximate attendance.

# Authorization for Medical Treatment for Minors

If your child needs medical or dental attention, you as a parent must give permission. It's the law. What about the times you can't be reached for permission? In a serious case, a physician can act right away to treat your child. In other cases, a hospital will authorize treatment, but only after making an effort to contact you first and that can mean unnecessary anxious moments for your child while someone tries to contact you. For those times when it will be hard to contact you, you can give permission to other adults. They can then act for you in permitting medical or dental care for your child when you're not available. This is a legal document. With it, you may appoint other adults to act for you.

*Complete this form and sign in front of a witness. DO NOT MAIL THIS FORM. It should be kept by the responsible adult.*

| NAME OF MINOR | BIRTHDATE | IDENTIFY ALLERGIES OR SPECIAL CONDITIONS |
|---------------|-----------|------------------------------------------|
|               |           |                                          |

**I/We, being the parent(s) or legal guardian(s) of the above named minor(s), do hereby appoint**

|                                  |                                                            |                                    |
|----------------------------------|------------------------------------------------------------|------------------------------------|
| <b>Name:</b><br>Jillian Felt     | <b>Address:</b><br>3234 NYS Rte. 49<br>Blossvale, NY 13308 | <b>Phone:</b><br>(315)<br>761-6562 |
| <b>Second Person (optional):</b> | <b>Address:</b>                                            | <b>Phone:</b><br>(315)             |

**To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor during the period of my/our absence from:**

*This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization as may be required.*

| Parent/Guardian                                |      | Parent/Guardian                 |      |
|------------------------------------------------|------|---------------------------------|------|
| SIGNATURE                                      |      | SIGNATURE                       |      |
| ADDRESS                                        | DATE | ADDRESS                         | DATE |
| Witness                                        |      | Witness                         |      |
| SIGNATURE                                      |      | SIGNATURE                       |      |
| ADDRESS                                        | DATE | ADDRESS                         | DATE |
| Hospitalization Coverage for above-named minor |      |                                 |      |
| INSURANCE COMPANY OR GOVERNMENT PROGRAM        |      | ID OR CONTRACT NUMBER           |      |
| Family Physicians                              |      |                                 |      |
| DOCTOR'S NAME AND PHONE NUMBER                 |      | DENTIST'S NAME AND PHONE NUMBER |      |