



**Town of Henderson Recreation Commission**

12105 Town Barn Road  
Henderson, New York 13650

*The Henderson/Ellisburg Summer Recreation Program's mission is to promote and enhance the development and wellness of our youth by offering a positive summer program of physical, educational, and social activities. Our aim is to provide valuable experiences in a well-supervised, caring, and nurturing environment.*

**PART A: Registration**

**A**

Child's Full Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_, NY Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Most recent grade completed: \_\_\_\_\_

Name of Father/Male Guardian: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_, NY Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

E-Mail: \_\_\_\_\_

Name of Mother/Female Guardian: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_, NY Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

E-Mail: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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**PART B: Informed Consent, Release Agreement, and Authorization B**

Child's Full Name: \_\_\_\_\_ Parent/Guardian Name (Print): \_\_\_\_\_

**2015 OFF-SITE PERMISSION**

New York State Department of Health Camp Health Code Regulations require us to obtain signed permission for every child attending Henderson/Ellisburg Summer Recreation to attend/participate in trips or activities that take place away from the recreation site.

By signing below, I give my child (named above) permission to participate in any and all recreation activities sponsored by the Town of Henderson Recreation Commission and to attend all off-site trips which can include but are not limited to: swimming at Southwick Beach State Park, walking into the Town of Henderson, trips to amusement parks, nature centers, zoos, movie theaters, or any other scheduled recreation trips or activities. I understand that my child will be supervised by summer recreation camp staff on all trips/off-site activities.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**2015 SWIMMING PERMISSION**

By signing below, I give my child (named above) permission to swim at Southwick Beach State Park on beach day trips. I understand the following:

- Campers will be transported to Southwick Beach State Park by school bus.
- Campers will be supervised by recreation staff, as well as qualified State Park Lifeguards at the site.
- Campers will be identified by their swim ability with a colored wrist band.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**PERMISSION TO PHOTOGRAPH**

I also hereby assign and grant to Henderson/Ellisburg Summer Recreation program, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of my child at all activities, and I hereby release the Town of Henderson Recreation Commission and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the Town of Henderson Recreation Commission and I specifically waive any right to any compensation I may have for any of the foregoing.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

# PART B: Informed Consent, Release Agreement, and Authorization

(continued)

**B**

## AUTHORIZATION TO PICK UP/DROP OFF

### Complete this section:

My child will get to the recreation program in Henderson (circle only one): Picked up at school in Belleville  
Picked up in Ellisburg      I will bring my child to the Pavilion in Henderson

My child will leave the recreation program (circle only one): Picked up at the Pavilion in Henderson  
Dropped off at school in Belleville      Dropped off in Ellisburg

Adults authorized to drop off/pick up my child for summer recreation:

You must designate at least one adult. Please include a telephone number. **Adults must be prepared to present their driver's license to summer recreation staff for identification purposes prior to release of a child into their custody.**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_

Adults NOT Authorized to drop off/pick up my child for summer recreation:

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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**PART C: General Information/Health History**

**C**

Child's Full Name: \_\_\_\_\_

Gender: \_\_\_\_\_ Height: \_\_\_\_\_ (inches) Weight: \_\_\_\_\_ (lbs.)

In case of emergency, in the event I cannot be reached, please contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Street Address: \_\_\_\_\_, City: \_\_\_\_\_, NY, Zip: \_\_\_\_\_  
 Home Phone: (315) \_\_\_\_\_ Cell Phone: (315) \_\_\_\_\_ Work Phone: (315) \_\_\_\_\_

Alternate Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Street Address: \_\_\_\_\_, City: \_\_\_\_\_, NY, Zip: \_\_\_\_\_  
 Home Phone: (315) \_\_\_\_\_ Cell Phone: (315) \_\_\_\_\_ Work Phone: (315) \_\_\_\_\_

**HEALTH HISTORY:**

Does your child currently have or has he/she ever been treated for any of the following?

Yes	No	Condition	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	Last HbA1c percentage and date:
<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease/heart murmur. Any heart surgery or procedure. Explain all "yes" answers.	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	Last attack date:
<input type="checkbox"/>	<input type="checkbox"/>	Ear/eyes/nose/sinus problems	
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal condition/muscle or bone issues	
<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells & dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/stomach/digestive problems	
<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue	
<input type="checkbox"/>	<input type="checkbox"/>	List all surgeries & hospitalizations	
<input type="checkbox"/>	<input type="checkbox"/>	List any other medical conditions not covered above	

# PART C: General Information/Health History (continued)

# C

Child's Full Name: \_\_\_\_\_

## ALLERGIES/MEDICATIONS

Is your child allergic to or does he/she have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medication		<input type="checkbox"/>	<input type="checkbox"/>	Plants	
<input type="checkbox"/>	<input type="checkbox"/>	Food		<input type="checkbox"/>	<input type="checkbox"/>	Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN.

Medication	Dose	Frequency	Reason

If your child should be restricted from any activity, please note: \_\_\_\_\_

Please identify any medical condition or medical history that would require special attention: \_\_\_\_\_

## SHOT RECORD

Please obtain a copy of your child's shot record from your pediatrician and submit it along with these documents.

## HEALTH INSURANCE INFORMATION

Carrier Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

I, the parent (guardian) of \_\_\_\_\_, give permission for my child to receive emergency medical or surgical treatment and hospitalization if necessary. I understand that every attempt will be made to contact me, or the emergency contact(s) I have named above, before taking this action. I will be financially responsible for any medical attention needed during recreation or resulting from an injury sustained at recreation. My medical insurance shall be the insurance coverage for any medical treatment. I further agree that my child can receive over-the-counter remedies (Tylenol, Sudafed, etc.) with the exception of: \_\_\_\_\_.

Please initial on this line \_\_\_\_\_ if you do not want your child to receive over-the-counter medications.

I hereby certify that my child is in good health and fully able to participate in all activities and that I know of no restrictions, physical impairments, or any other facts, which in any manner limit his/her participation in summer recreation.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_