Washtenaw Community College **Name: Last____________________ First:_________________**
CONTACT/PERMISSIONS FORM **Date of Birth:____/____/____**

SECTION 1: CONTACT INFORMATION

Primary Parent or Guardian:____

Home Address:____

Home Phone:___________________ Work or Cell Phone:__________________

Email:____

Secondary Parent or Guardian:____

Home Address:____

Home Phone:___________________ Work or Cell Phone:__________________

Email:____

If not available in an emergency, notify:

Name:____ Home Phone:_____________ Work or Cell Phone:_________________

Relationship:_____________________________________ Address:____

SECTION 2: AUTHORIZATIONS

Photography and Recording Permission: I hereby irrevocably release, consent and allow Washtenaw Community College and its agents to use and reproduce any and all photographs or video footage taken of me or my dependent(s) for WCC purposes. I understand that I/my dependent(s) receive no reimbursement for allowing my photo to be taken or for the use of the photo or video.

Parent/Guardian Signature____Date_______________

Liability: I hereby consent to the full participation of the aforementioned participants in the registered program. I release and hold harmless Washtenaw Community College, its officers and employees, from all liability for any injury or damage to person or property howsoever caused, resulting from participation by the aforementioned participant in the program.

Parent/Guardian Signature____Date_______________

Parent Packet Acknowledgement: I have read and understand in full the content of the Parent Packet. Furthermore I agree to follow the policies and guidelines covered in the packet.

Parent/Guardian Signature____Date_______________

Permission to Treat: I give permission to Washtenaw Community College to provide routine health care, dispense medications and secure emergency medical and/or emergency surgical treatment to my child while in care.

Parent/Guardian Signature____Date_______________

SECTION 3: CHILD RELEASE FORM

The camper may be picked up from WCC programs by the following person(s):

❒ Mother(s) and/or Father(s) **❒ Mother only** **❒ Father only**

OR, WCC has my permission to release the above named participant to the following people:

Name	**Relationship**	**Phone Number**
____________________________	______________________	_________________________
____________________________	______________________	_________________________
____________________________	______________________	_________________________

Signature of parent or guardian:_______________________________________ **Date:**____________________

SECTION 4: MEDICATION *(All medications must be sent to the program in **original containers**)*

❒ The participant **does not take** any medications on a routine basis
OR
❒ The participant takes the following **routine medications** (incl. over-the-counter/non-prescription medications):

Name of Medication	**Strength** (e.g. "100 mg")	**Dosage** (e.g. "2 pills")	**Time of day?** (e.g. "before dinner")	**Prescribing Physician**	**Reason for Taking (e.g. "allergies")**	**Other Instructions**

❒ The participant takes the following medications **AS NEEDED**
(includes inhalers, epi-pens, oral medications, topical medications or skin medications)

Name of Medication	**Strength** (e.g. "100 mg")	**Dosage** (e.g. "2 pills")	**Instructions for use if needed**	**Prescribing Physician**	**Reason for Taking**	**Other Instructions**

SECTION 5: ALLERGIES/DIETARY RESTRICTIONS *(To medicine, food, insect stings or bites, etc.)*

❒ The participant does not have any known allergies **OR**
❒ The participant has the following known allergies (peanut, seafood, bee stings, etc.):
❒ **IF APPLICABLE, PLEASE ATTACH COPY OF ALLERGY PLAN**

Allergy	**Reaction**	**Management of Reaction**

SECTION 6: PARTICIPANT'S HEALTH CARE PROVIDERS

Preferred Hospital in event of Emergency:_________________________

Primary Physician or Health Clinic:____ Phone:____________________

Address:____________________________________ Health Insurance Carrier:_______________________________

Policy Number:______________________________

SECTION 7: GENERAL HEALTH HISTORY

Please check below if the participant has or has had any of the following medical problems:

❒ Asthma
❒ Seizures/Epilepsy
❒ Hay Fever/Allergies
❒ Back Problems
❒ High Blood Pressure
❒ Bladder/Kidney Infection
❒ Vision or Hearing Problems
❒ Diarrhea/Constipation
❒ Headaches
❒ Heart Problems
❒ Scoliosis
❒ Head Injury
❒ Diabetes
❒ Depression
❒ Hernia
❒ Anemia
❒ Eating Disorder
❒ Sleep Problems
❒ Mononucleosis
❒ Heat Illness

❒ Chicken Pox (age: _____)
❒ Bleeding or Clotting Disorder
❒ Sickle Cell Anemia or Trait
❒ Anaphylactic Reaction
❒ Abnormal/painful menses
❒ ADD/ADHD/Learning Disorder
❒ Passed out during or after exercise
❒ Chest pain during or after exercise
❒ Skin problems (circle any that apply): rash eczema blisters itch acne infection warts scabs fungal

❒ Other ____

Please explain any special conditions/activity restrictions: ____

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❒ **IF APPLICABLE, PLEASE ATTACH COPY OF ASTHMA PLAN**