Volunteer Registration Form

Shirt Size ____________________

Participant:

First Name ______________________________________ Last Name: ____________________________________

Sex _____ Age _____ Date of Birth____ - ______ - ______Vision: Sighted Blind Visually Impaired

Mailing Address: ____

City: ____ State: ____________________ Zip:________________

Phone Number:( )___________________________ Cell Phone Number:( )_____________________

Referred by: _____________________________________ School:____

County: ____

Parent/Guardian:

First Name ______________________________________ Last Name: ____________________________________

Relationship to Participant: ________________________ Daytime Phone Number: ( )________________

Cell Phone Number:( )_____________________

Emergency Contact:

First Name ______________________________________ Last Name: ____________________________________

Home Phone Number: ( )______________________ Work Phone Number: ( ) ____________________

Cell Phone Number:( )______________________

Relationship to Participant:____(Other Than Parent)

FOR OFFICE USE ONLY

_____ HEALTH HISTORY

_____ MEDICAL INSURANCE INFO

_____ AUTHORIZATION FOR TREATMENT OF PARTICIPANT CONSENT, RELEASE & COVENANT

_____ PUBLICITY RELEASE & COVENANT

_____ COPY OF MEDICAL INSURANCE CARD

_____ CONFIRMATION PACKAGE ____/____/____

DATE ____

Health History

To be completed yearly by ALL participants, staff members and volunteers attending the Foundation's Recreation Programs.

Please read, fill out and send along with other enrollment forms. (Front and Back)

Participant:

First Name ________________________ Last Name: ________________________

Parent/Guardian:

First Name: ________________________ Last Name: ________________________

Health History: (Give approximate dates)

Frequent Ear Infections ________________________
Heart Defect/Disease ________________________
Convulsions ________________________
Diabetes ________________________
Bleeding/Clotting Disorders ________________________
Drugs ________________________
Other ________________________
Asthma ________________________

Allergies: (Dates Not Needed)

Hay Fever ________________________
Ivy Poisoning, etc. ________________________
Insect stings ________________________
Penicillin ________________________
Other ________________________
Hypertension ________________________
Mononucleosis ________________________
Psychiatric Treatment ________________________

Diseases: (Give approximate dates)

Chicken Pox ________________________ Measles ________________________
German Measles ________________________ Mumps ________________________

Has the participant ever required hospitalization?
If yes, explain.

____
____
____

Operations or serious injuries:

____
____
____

Disability or chronic illness:

____
____
____

Dietary modifications:

____

____

____

Name of Dentist/Orthodontist:

First Name: ______________________ Last Name: ______________________

Phone: ( ) ______________________

Suggestions on health related information:

____

____

For Minor Females: (Not Adults)

Has the person menstruated?______________________ if not, does the person have knowledge of menstruation? ______________________

If so, is her menstrual history normal? ______________________

Special consideration? ______________________

Immunization History:

Required immunizations must be determined locally. Please provide a copy of immunizations the participant has had performed.

Participants with Visual Impairments:

Diagnosis of Visual Impairment: ______________________

Age Visual Impairment Began: ______________________

Cause of Visual Impairment: _____ Accident _____ Illness _____ Unknown

Last Eye Examination: ______________________

Name of Ophthalmologist: ______________________

List any eye treatments or surgeries:

____

____

____

Does participant wear glasses or use optical aids? ______________________

Contact Lenses? ______________________

Other Physical Limitations:

Hearing ____________Speech ____________Smell ____________Orthopedic ____________

Developmentally Disabled: ______________ Epilepsy (seizures) ______________

Explain type: ______________________

Wheelchair: Yes ________ No ________

Medical Insurance Information

To be completed yearly by ALL participants, staff members
and volunteers attending the Foundation's Recreation Programs.

Please read, fill out and send along with other enrollment forms.

Current Medical Insurance is mandatory in order to participate in any recreation activities and events. Any medical costs incurred while participating in any Little Rock Foundation Recreation Program (Camp Little Rock) shall be the responsibility of participant's parents or guardian. Medical costs include physician visit, emergency room visit, prescription medication, and emergency transportation.

I (we) also understand and agree that any and all such medical; dental, hospital or similar expenses incurred in the treatment of my (our) child will be borne by myself (ourselves.)

If a situation requires medical treatment, the parent or guardian will be contacted by a camp staff member and informed of the situation and where the parent or guardian cannot be reached; the child will be taken to the local emergency room facility for treatment.

Please provide us with the following information.

Insurance Company name: ______________________________

Policy number: ______________________________

Participant:

First Name: ______________ Last Name: ______________

Parent/Guardian: (If under 18 years old)

First Name: ______________ Last Name: ______________

Signature: ______________ Date: ______________

Please include a photocopy of medical card being used by participant.

Authorization for Treatment of Participant
Consent, Release and Covenant

To be completed by ALL participants, staff members and volunteers attending the Foundation's Recreation Programs.

Please read, fill out and send along with other enrollment forms. (Front and Back)

The undersigned parent/guardian represents to the Little Rock Foundation that the minor named below is in his and/or her legal custody and control; and that the undersigned desires said minor to participate in the programs of the Little Rock Foundation, and that for purposes of said participation the undersigned agrees, authorizes and states as follows:

In case of medical or dental need or emergency, I (we) undersigned every effort will be made to contact parents/guardians of children. In the event I (we) cannot be reached, I (we) undersigned, parents/guardians of ______________________________, a minor, do hereby authorize the Little Rock Foundation and its officers or staff employees as agent(s) for the undersigned to obtain and consent to any X-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered to said minor under the general or special supervision of any and surgeon licensed under the provisions of the Medical Practice Act or the medical staff of a licensed hospital or by a dentist licensed under the provisions of the Dental Practice Act, whether such diagnosis of treatment is rendered at the office of said physician or dentist or the said hospital.

I (we) also understand and agree that any and all such medical; dental, hospital or similar expenses incurred in the treatment of my (our) child will be the responsibility of the parent.

It is understood that this authorization is given in advance of any specific medical or dental diagnosis, treatment or care being required but is given to provide authority and power on the part of the Little Rock Foundation (as aforesaid) as my (our) agent(s), to give specific consent to any and all such diagnosis, treatment or care which a licensed physician or dentist in the exercise of his/her best judgment may deem advisable.

This authorization shall remain effective while the child is enrolled in the Foundation's Recreation Programs, unless sooner revoked in writing and delivered.

The undersigned further releases the Little Rock Foundation, its officers, agents and employees from any and all legal responsibility for accidents or sickness occurring during or related to the period of time said person is a participant in programs of the Little Rock Foundation. I (we) further agree and covenant (for valuable consideration, receipt of which is acknowledged) that neither said person or I (we) will institute any suite or action of damage, loss or injury of any kind, whether to person or property, whether to me (us) individually or as parents/guardians relating to the programs or activities of the Little Rock Foundation (including but not limited to Camp Little Rock in which the person participates.)

Participant:

First Name: ________________________ Last Name: ________________________

Parent/Guardian: (If under 18 years old)

Relationship to Participant: ____

First Name: ________________________ Last Name: ________________________

Signature: __________________________ Date: ______________________________

CAMP LiTTLE ROCK

Authorization for Publicity Consent and Release

To be completed yearly by ALL participants, staff members
and volunteers attending the Foundation's Recreation Programs.

Please read, fill out and send along with other enrollment forms.

Permission is hereby given to the Little Rock Foundation to take pictures, video tape, live television, or otherwise record, preserve, reproduce or depict the activities, voice and likeness of ________________________ (Participant's Name) and to use any and all of the same for publication, without compensation to said person or to the undersigned on his/her behalf, or individually.

Participant:

First Name: ___________________________ Last Name:___________________________

Parent/Guardian: (If under 18 years old)

First Name: ___________________________ Last Name:___________________________

Signature:_____________________________ Date:________________________________