Oak Brook Park District

ABC Preschool

Important Forms

***WELCOME** to the Oak Brook Park District ABC Preschool program! All forms in this booklet must be filled out and returned to your child's teacher.*

If you have any questions or concerns, please contact the Recreation Manager at (630) 645-9516.

Oak Brook Park District
1450 Forest Gate Road
Oak Brook, IL 60523
Phone: (630) 990-4233
Fax: (630) 990-8379
www.obparks.org

OAK BROOK 19 62 PARK DISTRICT

Oak Brook Park District

ABC Preschool Emergency Contact/Pick-Up Form

Child's Name _____

Parent/Legal Guardian Allowed to Pick-Up

1. Parent/Legal Guardian _____
   Address _____
   City _____ State _____ Zip Code _____
   Home Phone _____ Work Phone _____
   Cell Phone _____ Email _____ _____

2. Parent/Legal Guardian _____
   Address _____
   City _____ State _____ Zip Code _____
   Home Phone _____ Work Phone _____
   Cell Phone _____ Email _____ _____

Additional people who are authorized to pick up my child. ***(Drivers License or State ID will be required)***

1. Name _____ Relationship _____
   Address _____
   City _____ State _____ Zip Code _____
   Home Phone _____ Work Phone _____
   Cell Phone _____

2. Name _____ Relationship _____
   Address _____
   City _____ State _____ Zip Code _____
   Home Phone _____ Work Phone _____
   Cell Phone _____

3. Name _____ Relationship _____
   Address _____
   City _____ State _____ Zip Code _____
   Home Phone _____ Work Phone _____
   Cell Phone _____

4. Name _____ Relationship _____
   Address _____
   City _____ State _____ Zip Code _____
   Home Phone _____ Work Phone _____
   Cell Phone _____

Unauthorized Pick-Up ***(People who CANNOT pick up your child our programs.)***

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

A late fee will be charged if you are late to pick up your child, $1.00 for every one minute. Time is measured by the watch/ clock of the teacher doing sign out.

I, _____ authorize the people listed above to pick up my child and be contacted in the event of an emergency from the Oak Brook Park District Preschool Program. In doing so, I relieve the Oak Brook Park District of all responsibility for my child after he/she has been released from the program. Attempts will be made to reach the parent/ legal guardian first.

Parent's Name *(print)* _____

Parent's Signature _____ Date _____

Oak Brook Park District

CHILD INFORMATION SURVEY

Child's Name (print) _____ Date of Birth _____
Parent's Name (print)_____

In what school district will your child attend K-8? Circle One: Butler 53 Other_____

Please answer the following questions to help us begin to know and understand your child.
Check all the answers that apply and feel free to elaborate where necessary.

Does your child know: ❒ Own Name ❒ Address ❒ Phone Number

List one or two of your child's favorite books or stories.
1. _____ 2._____

What special interest areas does your child have that we might enjoy exploring in our programs?_____
_____

Has your child previously attended our programs? ❒ Yes ❒ No

Name(s) & Date of Birth of Siblings
Name_____ DOB _____ Name _____DOB _____
Name_____ DOB _____ Name _____DOB _____

Does anyone in your home speak a language other than English? ◯ NO ◯ YES
If yes, what language? _____

Does your child speak a language other than English? ◯ NO ◯ YES
If yes, what language? _____

Who are your child's favorite playmates and what are their ages?
Name_____ Age_____ Name _____Age _____
Name_____ Age_____ Name _____Age _____

Do you have any concerns about how your child gets along with other children? ❒ Yes ❒ No
If yes, please describe_____

Does your child prefer to use the left or right hand? _____

Is your child afraid of:
❒ dogs ❒ birds ❒ thunder ❒ the dark
❒ insects ❒ other Please Specify_____

Do you have any special talents or skills that you would like to share with our programs? _____
_____

Allergies:_____

Dietary Restrictions:_____

Please add any information you feel will help us to meet your child's special needs._____
_____

Oak Brook Park District

PERMISSION TO DISPENSE MEDICATION
WAIVER AND RELEASE OF ALL CLAIMS

The Oak Brook Park District will not dispense medication to a minor child or other participant until the Permission and Waiver to Dispense Medication and Medication Information Form have been fully completed by a parent or guardian. The agency's internal procedures on dispensing medication are available for review.

Program Name _____Date _____

I_____the parent/guardian of_____
(Print Name)

give permission to the staff of the Oak Brook Park District to administer to my child the following medication:

_____
(Name of Medication)

I understand it is my responsibility to give the medication directly to the program staff in individual dosage containers, original prescription containers, or envelopes clearly labeled with the following information:.

Participant's Name *(print)* _____

Name of medicine and complete dosage instructions_____

_____

_____

_____

_____

_____

In all cases, the recommended dosage of any medication will not be exceeded.

If after administering medication, there is an adverse reaction, I give my permission to the Oak Brook Park District to secure from any licensed hospital physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered.

I recognize and acknowledge that there are certain risks of physical injury in connections with the administering of medication to my minor child. In consideration of the Oak Brook Park District administering medication to my minor child, I do hereby fully release or discharge the Oak Brook Park District and its officers, agents, volunteers and employees from any and all claims from injuries, damages and losses I or my minor child may have, arising out of, connected with, incidental to, or in any way associated with the administering of medication. I further agree to indemnify, hold harmless and defend the Oak Brook Park District, and its officers, agents, volunteers and employees from any and all claims resulting from injuries, damages and losses sustained by me or my minor child and arising out of, connected with, incidental to or in any way associated with the administering of medication.

Parent's Name *(print)*_____

Parent's Signature _____Date _____

Oak Brook Park District

WAIVER & RELEASE OF ALL CLAIMS FOR USE OF INHALER OR AUTO-INJECTOR (EPI-PEN)

WAIVER AND RELEASE OF ALL CLAIMS AND INDEMNIFICATION

Please read this form carefully and be aware that pursuant to the Illinois Asthma Inhalers at Recreational Camps Act, 410 ILCS 607/1 et seq., you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages or loss which you or your minor child/ward might sustain in connection with the possession, self-administration, or use of medication, including, but not limited to the use of an epinephrine auto-injector or inhaler at the camp or at any camp-sponsored activity, event, or program; except for claims arising out of the willful and wanton conduct of the Oak Brook Park District.

As parent/guardian of the below identified participant, I verify and attest that my child/ward has the knowledge and skills to safely possess, self-administer, and use an epinephrine auto-injector or inhaler in a camp setting. I also recognize and acknowledge that there are certain risks of physical injury to participants' possession, self-administration, or use of medication, and I voluntarily agree to assume the full risk of any and all injuries, damages or loss, regardless of severity, that my minor child/ward or I may sustain as a result of said possession, self-administration, or use of medication. Such risks include, but are not limited to, failing to properly administer the medication, failing to observe side effects, failing to assess and/or recognize an adverse reaction, failing to assess and/or recognize a medical emergency, and failing to recognize the need to summon emergency medical services.

I further agree to waive and relinquish all claims I or my minor child/ward may have (or accrue to me or my child/ward) as a result of or arising out of the possession, self-administration, or use of medication against the (District/SRA), including its officials, agents, volunteers and employees; except for claims arising out of the willful and wanton conduct of the Oak Brook Park District.

I further agree to protect, indemnify, save defend and hold harmless the Oak Brook Park District from and against any and all liabilities, obligations, claims, damages, penalties, causes of action, costs and expenses (including reasonable attorney fees) for which the Oak Brook Park District may become obligated by reason of the possession, self-administration, or use of medication; except to the extent caused by the willful and wanton conduct of the Oak Brook Park District.

I have read and fully understand the above waiver and release of all claims and indemnification. If registering on-line or via fax, my on-line or facsimile signature shall substitute for an have the same legal effect as an original form signature.

Participant's Name *(print)* _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Email _____

Parent's Name *(print)*_____

Parent's Signature _____Date _____

Participation will be denied if the signature of the parent/guardian and date are not on this waiver.

Oak Brook Park District

MEDICATION INFORMATION

THIS FORM MUST BE COMPLETED FOR EACH PROGRAM SESSION OR WHEN MEDICATION CHANGES.

Program Name _____

Participant's Name *(print)* _____ Age _____
Parent's Name *(print)* _____
Address _____
City _____ State _____ Zip _____
Home Number _____ Cell Phone _____
Email _____

Doctor's Name _____
Address _____
City _____ State _____ Zip _____
Phone Number _____

MEDICATION INFORMATION

1. Name _____ Dose ____Time _____

   Storage instructions and specific recommendations for administration _____
   _____
   _____

   Possible side effects and instructions _____
   _____
   _____

   Any severe adverse reactions that may occur to another child, if they come in contact with or receive a dose of medication.
   _____
   _____

2. Name _____ Dose ____Time _____

   Storage instructions and specific recommendations for administration _____
   _____
   _____

   Possible side effects and instructions _____
   _____
   _____

   Any severe adverse reactions that may occur to another child, if they come in contact with or receive a dose of medication.
   _____
   _____

Other Information _____
_____

I understand that it is my responsibility to give the medication directly to program staff with full instructions in individual dosage containers, clearly labeled envelopes, or in original prescription bottles.

In all cases, medication dispensing can only be changed or modified by completing another Permission and Waiver to Dispense Medication Form and Medication Information Form.

I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, guardian, ward, or other family member is accurate. I also understand that it is my responsibility to inform the agency if any changes in the dispensing of medication change.

Parent's Signature _____ Date _____