Circles® Orange County
Thriving Families, Thriving Communities

MULTIPLE CHILDRENS INFORMATION FORM 2017

1) Child Name: _____ **Age:** _____
Last First M.Intial

Sex ☐Female☐ Male **Birth Date:** ____/____/_____ **Grade:** _____

2) Child Name: _____ **Age:** _____
Last First M.Intial

Sex ☐Female☐ Male **Birth Date:** ____/____/_____ **Grade:** _____

3) Child Name: _____ **Age:** _____
Last First M.Intial

Sex ☐Female☐ Male **Birth Date:** ____/____/_____ **Grade:** _____

4) Child Name: _____ **Age:** _____
Last First M.Intial

Sex ☐Female☐ Male **Birth Date:** ____/____/_____ **Grade:** _____

5) Child Name: _____ **Age:** _____
Last First M.Intial

Sex ☐Female☐ Male **Birth Date:** ____/____/_____ **Grade:** _____

Parent/Guardian: _____ **Phone:** _____

Home Address_____
Street City State Zip

If not available in an emergency, please notify:

Name: _____ **Phone:** _____

Address: _____
Street City State Zip

HEALTH HISTORY

Child # 1 Name: _____

Any known health issues we should be aware of? ☐Yes ☐No

If YES please explain: _____
_____

Allergies: ☐None ☐Hay Fever ☐Poison Ivy, Etc. ☐Insect Stings ☐Penicillin
☐Other Medications☐ Asthma ☐Other: _____

Current Medications: (please send with instructions): ☐None
_____

Dietary Modifications: ☐Yes ☐No

If YES please explain: _____
_____

Disability, Behavioral Barriers, or Limitations we should know about ☐Yes ☐No

If YES please explain: _____
_____

Name of child's Physician: _____ Phone: _____

Date of last Physical Exam: _____

Child # 2 Name: _____

Any known health issues we should be aware of? ☐Yes ☐No

If YES please explain: _____
_____

Allergies: ☐None ☐Hay Fever ☐Poison Ivy, Etc. ☐Insect Stings ☐Penicillin
☐Other Medications☐ Asthma ☐Other: _____

Current Medications: (please send with instructions): ☐None
_____
_____

Dietary Modifications: ☐Yes ☐No

If YES please explain: _____
_____

Disability, Behavioral Barriers, or Limitations we should know about ☐Yes ☐No

If YES please explain: _____
_____

Name of child's Physician: _____ **Phone:** _____

Date of last Physical Exam: _____

Child # 3 Name: _____

Any known health issues we should be aware of? ☐Yes ☐No

If YES please explain: _____
_____

Allergies: ☐None ☐Hay Fever ☐Poison Ivy, Etc. ☐Insect Stings ☐Penicillin
☐Other Medications☐ Asthma ☐Other: _____

Current Medications: (please send with instructions): ☐None
_____

Dietary Modifications: ☐Yes ☐No

If YES please explain: _____
_____

Disability, Behavioral Barriers, or Limitations we should know about ☐Yes ☐No

If YES please explain: _____
_____

Name of child's Physician: _____ **Phone:** _____

Date of last Physical Exam: _____

Child # 4 Name: _____

Any known health issues we should be aware of? ☐Yes ☐No

If YES please explain: _____
_____

Allergies: ☐None ☐Hay Fever ☐Poison Ivy, Etc. ☐Insect Stings ☐Penicillin
☐Other Medications☐ Asthma ☐Other: _____

Current Medications: (please send with instructions): ☐None

_____

Dietary Modifications: ☐Yes ☐No

If YES please explain: _____

_____

Disability, Behavioral Barriers, or Limitations we should know about ☐Yes ☐No

If YES please explain: _____

_____

Name of child's Physician: _____ **Phone:** _____

Date of last Physical Exam: _____

Child # 5 Name: _____

Any known health issues we should be aware of? ☐Yes ☐No

If YES please explain: _____

_____

Allergies: ☐None ☐Hay Fever ☐Poison Ivy, Etc. ☐Insect Stings ☐Penicillin
☐Other Medications☐ Asthma ☐Other: _____

Current Medications: (please send with instructions): ☐None

_____

Dietary Modifications: ☐Yes ☐No

If YES please explain: _____

_____

Disability, Behavioral Barriers, or Limitations we should know about ☐Yes ☐No

If YES please explain: _____

_____

Name of child's Physician: _____ **Phone:** _____

Date of last Physical Exam: _____

Suggestions or other information for program personnel:

_____
_____
_____
_____
_____

******IMPORTANT***This Box Must Be Complete For Attendance!!!******

This application and all information given are correct to my knowledge. The person herein described has permission to engage in all prescribed children activities except as noted.

Emergency Authorizations: I hereby give permission to the medical personnel selected by the children's program personnel to order X-rays, routine tests, and treatment for me/or my child, EVEN if I can not be reached in an emergency. I hereby give my permission to the physician selected by the personnel to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/or my child as named above.

Tobacco, Alcohol, and Drug Policy: Children are prohibited from possessing or using tobacco and alcohol products and any illegal substances during the children's program. For the protection of all concerned, staff reserves the right to search campers and their personal belongings to enforce this policy. Campers who are found to have violated this rule are subject to expulsion from camp.

I understand the policies as stated above and give my permission for my child to attend:

Parent/Guardian:_____ Date:_____

Photo/Video Release Agreement

I, _____ hereby consent to the photographing of myself and the recording of my voice and the use of these photographs and/or recordings singularly or in conjunction with other photographs and/or recordings for advertising, publicity, commercial or other business purposes. I understand that the term "photograph" as used herein encompasses both still photographs and motion picture footage.

I further consent to the reproduction and/or authorization by St. Luke's United Methodist Church to reproduce and use said photographs and recordings of my voice, for use in all domestic and foreign markets. I hereby release St. Luke's United Methodist Church, and any of its employees or associates from all claims of every kind on account of such use.

If participant is under 18 years of age, I, _____, am the parent/legal guardian of the individual named above. I have read this release and approve of its terms.

Print Name: _____ **Date:** _____

Signature: _____