

# Conshohocken Summer Camps

Borough of Conshohocken  
Department of Recreation Services and Parks  
610-828-3266  
<http://conshohockenrsp.recdesk.com>

## Medication Administration and Release of Liability

Borough of Conshohocken/Program Providers will:

- Only allow a staff member or program provider over the age of 16 to administer any prescription and nonprescription medication.
- Keep all medication stored in an area of the facility that is out of reach of children, including EpiPens and inhalers.

Parents/Guardians will:

- Provide written consent for the administration of the prescription or nonprescription drug (Fill out the Medical Authorization and Release Form).
- Ensure prescription or nonprescription medication is in an original container.
- Provide written instructions for the administration of the medication. Instructions on a prescription label are acceptable.
- Put a label on the medicine container identifying the name of the child the medication is for.
- Pick up the medication immediately after its effective date or on the child's last day of the program.

## Borough of Conshohocken Certification of Medical Fitness and Vaccination Status For Participants in Summer Camp / Recreation Program

The Borough of Conshohocken is committed to providing a healthy, safe and affordable recreational experience to residents and their guests. To safeguard program participants, the Borough of Conshohocken must request confirmation from all program participants that they are medically fit to participate and that they meet minimum public health vaccination standards.

**Please have the participant's physician complete the enclosed physical examination form. Medical/vaccination certification forms obtained for school or day care purposes will also be accepted. Note: Your child will not be permitted to participate until this form is returned.**

**MEDICAL AUTHORIZATION AND RELEASE**

I hereby authorize the Borough of Conshohocken and its employees, volunteers, agents and program providers to administer the following medication to my minor child (ren) as specified:

<u>Child Name</u>	<u>Age</u>	<u>Medication</u>	<u>Dosage</u>

I understand and agree that the Borough of Conshohocken, its program personnel, Council members, officials, employees, departments and affiliated entities shall not be liable in any way for any personal injuries sustained by my minor child as a result of administering the above described medication(s) and that the administration of those medications is subject to the Liability Waiver and Release which is incorporated herein by reference. I also hereby authorize the Borough of Conshohocken or its program providers to secure emergency medical care for my minor children should they suffer any injury or otherwise require such care while participating in any Borough of Conshohocken sponsored programs.

Should it be necessary for any of the Borough of Conshohocken program personnel to provide any emergency medical care for my minor child (ren), I acknowledge and understand that the Borough of Conshohocken, its program personnel, Council members, officials, employees, departments, agents and affiliated entities shall not be liable in any way for any person injuries arising from such care and that all such activities are also subject to the Liability Waiver and Release.

Intending to be legally bound hereby, and with full authority, I acknowledge, agree to and accept the terms of this Medical Authorization and Release of behalf of myself and my minor child (ren).

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

Name(s) of minor child (ren):

Signature: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

**MEDICAL INFORMATION**

Is your child being treated for any of the following?(Circle one)

Diabetes     Asthma     ADD     ADHD     Autistic Spectrum     Allergies

Please Explain: \_\_\_\_\_

Other Medical Conditions     Please Explain: \_\_\_\_\_

Medication: \_\_\_\_\_

Any other medical information/special needs we should be aware of?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian #1

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

Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Parent/Guardian # 2

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

Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_

Email Address: \_\_\_\_\_

**I understand that every precaution is taken to secure the safety of each participant, however, in case of an accident; I agree to release the Borough of Conshohocken from any liabilities.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PHYSICAL EXAMINATION FORM**

In case of Emergency, the Borough of Conshohocken is authorized to seek medical attention from emergency services and/or:

Doctor \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Practice \_\_\_\_\_

Address \_\_\_\_\_

**TO BE COMPLETED BY PARENT:**

Name of participant (Print): \_\_\_\_\_ will be taking part in a summer camp/recreation program to include the following physical activities.

(Provide examples of activities or attach a program description): \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN:**

By affixing my signature below, I certify that based on my examination of the participant:

**Check One:**

\_\_\_\_\_ He/She is physically able to participate in the activity without requiring accommodations

\_\_\_\_\_ He/She is physically able to participate in the activity but requires the following accommodations:

\_\_\_\_\_  
\_\_\_\_\_

**Check One:**

\_\_\_\_\_ He/She is up to date with vaccinations required under Title 28 PA code 23.82 (school vaccinations) and/or Title 28 PA code 27.77 (Childcare vaccinations)

\_\_\_\_\_ He/She is medically exempt from vaccinations as per Title 28 PA code 23.84 (a)

\_\_\_\_\_ Parents/guardians claiming exemption from vaccination on religious grounds per Title 28 PA Code 23.84 (b)

**Certification:**

Physician Name (print): \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**RELEASE OF LIABILITY WAIVER**  
**Recreation Services and Parks Department**  
**Conshohocken Community Center at the Fellowship House**

**General Waiver**

As a participant or as the parent/guardian of a participant in this program, I recognize and acknowledge that there are certain risks of physical injury and I agree to assume the full risk of any injuries, including death, damages, or loss which the participant may sustain as a result of participating in any and all activities connected with or associated with such program.

As a participant or as the parent/guardian of a participant in this program, I do hereby fully release and discharge the **Borough of Conshohocken** and its officers, agents, servants, and employees from any and all claims from injuries, including death, damage, or loss which I or the participant may have or which may accrue to me or the participant on account of my, or the participant's, participation in the program.

As a participant or as the parent/guardian of a participant in this program, I agree to waive and relinquish all claims the participant or I may have as a result of participating in the program against the **Borough of Conshohocken**, its officers, agents, servants, and employees.

As a participant or as the parent/guardian of a participant in this program, I further agree to indemnify and hold harmless and defend the **Borough of Conshohocken Department** and its officers, agents, servants, and employees from any and all claims resulting from injuries, including death, damages, and losses sustained by the participant and arising out of, connected with, or in any way associated with the activities of the program.

I certify that I am in good physical health and have no limitations other than those I have listed during registration, which may predispose me to risk during this program.

I also grant permission to supervising, managing personnel or other **Borough of Conshohocken Department of Recreation Services and Parks and the Community Center at the Fellowship House** representatives to authorize and obtain medical care from any licensed physician, hospital or medical clinic should I, or my child, become ill or injured while participating in activities when I am unable to grant authorization for emergency treatment which treatment shall be at my expense. This form shall be considered valid until cancelled or changed in writing by the undersigned.

**REFUND POLICY**

I understand and agree to the activity refund policy that a full refund will only be given when a program is cancelled by **Borough of Conshohocken Department of Recreation Services and Parks and the Community Center at the Fellowship House**. A refund request at least five (5) business days prior to the program, or one (1) week prior to park rentals, will receive a refund less 5%. NO REFUNDS will otherwise be given. All refunds are subject to State Board of Accounts claim procedures and may take up to seven (7) business days to process. *Note: Please be advised that Jump Start Sports and other program providers may have their own refund policy. Please check registration details if applicable.*

**PHOTO RELEASE**

I give permission to the **Borough of Conshohocken Department** for the free use of my likeness and that of my child or ward, in connection with any broadcast, telecast, video, photograph, print media, or other publicity.

**By signing below, I acknowledge that I have read and understand the above Waiver & Release Agreement and I fully understand that "THIS IS A RELEASE" and further agree to abide by the rules above. (Parent or Guardian acknowledgment if Participant is under 18 years old.)**

Participant Name (Print): \_\_\_\_\_

Camp Name: \_\_\_\_\_ Age Group: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian (Print): \_\_\_\_\_

Signature (Parent or Guardian): \_\_\_\_\_

**\*\*RETURN FORMS WITH PROGRAM REGISTRATION MATERIALS AND PAYMENT\*\***