BURLINGTON
PARKS
RECREATION
WATERFRONT

Burlington Parks, Recreation & Waterfront
Miller Community Recreation Center
130 Gosse Court, Burlington, VT 05408
(802) 864-0123

YOUTH PROGRAM INFORMATION FORM

This form is valid for one calendar year (January 1- December 31) and covers any and all programs that your child participates in during that time. If any information changes throughout the year, please update it when registering for programs.

Child's Name: _____ Date of Birth: _____

Grade (fall of current year): _____ Age: _____ Gender: _____

Parent/Guardian 1 Name:_____Email:_____

Address:_____

Phone #(s): _____

Parent/Guardian 2 Name:_____Email:_____

Address:_____

Phone #(s): _____

The following people have permission to pick up my child:

Name:_____Relation:_____Phone:_____

Name:_____Relation:_____Phone:_____

PERMISSION FORM

Permissions below cover any and all programs that your child participates throughout the year. Please inform staff if there are changes related to a specific program.

DO	DO NOT	
☐	☐	I grant permission for my child to participate in all field trips. This includes any walking and/or bus field trips.
☐	☐	I grant permission for my child to watch a PG movie.
☐	☐	I grant permission for the City of Burlington or its agents to photograph or record my image or voice (or if the participant is a minor, my child's image or voice), during recreation programs and activities, without payment or consideration. I understand that any such photographs or recordings will become the property of the City of Burlington.
☐	☐	I give permission for the BPRW staff to contact my child's school personnel including principal, guidance counselor, teacher, or special educator, if needed, to develop a support plan.
☐	☐	I give permission to obtain my child's immunization records
☐	☐	I give permission for my child to participate in swimming activities
☐	☐	I give permission for staff to apply sunscreen
☐	☐	I give permission for my child to walk/bike home on their own
☐	☐	I give permission for BPRW staff to contact my child's physician/dentist or to seek emergency medical care in an emergency

SIGN:_____ DATE:_____

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Child's Name: _____ Date of Birth: _____

MEDICAL INFORMATION

Check boxes that apply and please provide detail

____Food, bees, or other allergies:_____

_____

Please describe any reactions: _____

_____

_____

____Physical limitations:_____

_____

____Special dietary requirements:_____

_____

____Medication required:_____

_____

If medication needs to be administered during a program, please complete the Medication Administration Form

____Other special needs:_____

_____

____Does your child have an IEP, 504 Plan, or aid during school? YES NO

If yes, please describe support: _____

_____

EMERGENCY CONTACT INFORMATION

Emergency Contact 1 Name:_____ Relation:_____

Phone #(s):_____

Address:_____

Emergency Contact 2 Name:_____ Relation:_____

Phone #(s):_____

Address:_____

Child's Dentist:_____Phone: _____

Child's Physician:_____Phone: _____