



YOUTH PROGRAM REGISTRATION FORM- 2023

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 2022): _____ 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: _____



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: _____