

VILLAGE OF ORLAND PARK RECREATION AND PARKS DEPARTMENT
14600 S. Ravinia Avenue
Orland Park, IL 60462

Date and Trip Destination _____

Name _____ Age _____ Birthdate _____

Address _____ City _____ Zip _____

Home Phone _____ Dad's Phone _____ Mom's Phone _____

Emergency Contact Name _____ Phone _____

Your son/daughter should function independently in the skills listed below, however, please provide any information you feel would be helpful to staff.

Grooming: Independent ____ Needs coaching ____ Other ____

Toileting: Independent ____ Needs reminders ____ Bed wetting ____

Sleep habits: Sleep walks ____ Talks in sleep ____

Usual bedtime _____ Usual wake up time _____

Does your son/daughter have unusual eating habits? _____

If yes, please describe: _____

Is this his/her first time away from home? Yes ____ No ____

Does your son/daughter have any motion sickness? Yes ____ No ____

Please list activities your son/daughter enjoys: (i.e. swimming, walking, amusement rides, shows, etc.) _____

Physical activity restrictions: _____

Does your son/daughter have sun sensitivity? Yes ____ No ____

Do you give permission for your son/daughter to drink alcohol on this trip? Yes ____ No ____
If yes, how much? _____

If you will be away from home while your son/daughter is on this trip, please fill out the information below:

Location: _____ Hotel or Home: _____

Address: _____ Phone: _____

Please attach a photocopy of the participant's insurance card.

Health Information and History

Is your son/daughter subject to seizures? _____ If so, please describe the type of seizure.
After the seizures, how does he/she react? _____

Frequent ear infections _____

Heart defect/disease _____

Diabetes _____

Bleeding _____

Clotting disorders _____

Stomach problems _____

Fainting _____

Asthma _____

Date of last tetanus shot _____

Name of dentist/orthodontist _____ Phone _____

Name of family physician _____ Phone _____

Chronic or recurring illnesses _____

Allergies (please check appropriate box)

Penicillin _____

Insect stings _____

Other _____

Current Medication

Please list all prescriptions that will need to be taken on the trip as well as over-the-counter medications your son/daughter may take on the trip.

Medication name	Frequency/Dose per time	Dose per day
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you give the Orland Park Recreation Staff permission to dispense medication to your son/daughter on the trip? Yes _____ No _____ Signature _____

If no, explain _____

Medical Insurance Information

Name of insurance company _____

Address _____

Phone number _____ Policy number _____

If your son/daughter needs medical attention on this trip while in our care, do you give the group leader permission to take them to the hospital or physician? Yes _____ No _____

Comments: _____

Signature: _____