

## RAC Camp Registration Forms

Please confirm your selected weeks

### RAC Camp

**Week #1 – July 5<sup>th</sup> – 9<sup>th</sup>**

**Week #2 – July 12<sup>th</sup> – 16<sup>th</sup>**

**Week #3 – July 19<sup>th</sup> – 23<sup>rd</sup>**

**Week #4 – July 26<sup>th</sup> – 30<sup>th</sup>**

**Week #5 – August 3<sup>rd</sup> – 6<sup>th</sup> (Closed August 2<sup>nd</sup> Civic Holiday)**

**Week #6 – August 9<sup>th</sup> – 13<sup>th</sup>**

**Week #7 – August 16<sup>th</sup> – 20<sup>th</sup>**

**Week #8 – August 23<sup>rd</sup> – 27<sup>th</sup>**

[\\*\\*\\*Please remember if you do not receive a confirmation email you are not registered](#)

**Child Participant Information**

Child's Name:

Preferred name:

Birthdate:            /        /        /  
(Day/Month/Year)

Age:

Name of Sibling (if also in attendance):

**Contact Information**

<u>Parent/Guardian #1</u>	<u>Parent/Guardian #2</u>
Full Name:	Full Name:
Relationship to Child:	Relationship to Child:
Phone number:	Phone number:
Alternative Number:	Alternative Number:
Email:	Email:
Home Address:	Home Address:

Emergency Contact #1	Emergency Contact #2
Full Name:	Full Name:
Relationship to Child:	Relationship to Child:
Phone number:	Phone number:
Alternative Number	Alternative Number

\*Emergency contacts should be different people than parent/guardians

List of people who may pick up your child from our program. (They will be asked for identification)	

**Medical Information**

Health card Number:

Does your child have any **food allergies** or **dietary restrictions**?

Please list any **medical conditions** or/and **allergies**:

Please list any **medications** your child is currently taking (please include dosage and frequency):

Does your child require an EpiPen? For which allergy is this required?

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Please identify and explain any special needs or exceptionalities as they pertain to you child:

**Medical/Risk Release**

In the event of an accident, incident, or medical emergency I, \_\_\_\_\_ give permission for First Aid to be administered and to obtain immediate medical assistance for my child, \_\_\_\_\_. I give permission for my child to be transported to a hospital by ambulance. I understand that every effort will be made to contact guardians immediately.

I \_\_\_\_\_, give my child, \_\_\_\_\_ permission to take part in community outings to local parks, libraries, and businesses.

**Ralph Thornton Community Centre staff** shall not be held responsible for any acquired injuries or loss of personal property. I also recognize that the right to participate depends upon the individual's respect for the program, properties, rules, equipment, and staff.

Ralph Thornton Community Centre cannot guarantee a nut or other allergy free zone as we operate out of public use spaces. We cannot be held responsible if you child encounters allergies resulting in any allergic reactions.

Name:

Signature:

Date:

Ralph Thornton Community Centre respects your privacy. We adhere to legislative requirements with respect to protecting your privacy. The information on this form will be used to process your application for program participation, to deliver services, and to keep you informed and up to date about Ralph Thornton Community Center activities.

## Multimedia Consent Form

I, \_\_\_\_\_ give the Ralph Thornton Community Centre (RTCC) permission to a) photograph, b) videotape, c) make an audiotape of, d) post on any of the Ralph Thornton Community Centre's social media handles (i.e. Facebook, twitter, website, etc.) e) film and/or interview me or the children named below.

I also give the RTCC permission to publish the photographs, videotapes, audiotapes, films and/or interviews it makes for use in RTCC publications and printed material. The publications can include marketing and promotional materials.

The photographs, videotapes, etc. shall be the exclusive property of RTCC. The photographs etc. may be reproduced by RTCC and anyone it has authorized. No compensation or payment will be given to the individual(s) in the photographs, videotapes, etc.

### Please Print

Parent/Guardian's Name:

**Signature:**

**Date:**

Child/Children's Name(s):

## Food Allergy/Dietary Needs

Please attach medical documentation describing the dietary restrictions due to the food allergy and/or intolerance, from the Participant's Physician.

### **Food Allergy**

Dairy	Soy	Eggs
Peanuts	Tree nuts	Shellfish
Sesame	Fish	Wheat

Other, please list:

Other Special Diet needs or restrictions:

### **Dietary Needs Questionnaire Please answer the following questions to better help us with your needs:**

1. What are the preferred food substitutions, if any? (soy butter for peanut butter, gluten free breads, soy milk etc.):

What types of contact will cause a reaction?

Airborne

Trace Cross Contact

Actual ingestion of food

Please explain:

3. Does the Participant understand the food allergy and what needs to be done to manage it?

4. Has the Participant ever attended camp or eaten meals outside the home? If yes, how were the meals handled?

5. Is there any other information you would like to share to help us meet the Participant's needs?