

## Recreation Programming | Participant Information Form

**Name of Participant:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_  
**Name of program/camp:** \_\_\_\_\_  
**Location:** \_\_\_\_\_ **Start Date:** \_\_\_\_\_

**Name of Parent/Guardian:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Emergency contact:** (*Different than Parent/Guardian*)

**Name:** \_\_\_\_\_ **Relationship to Participant:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Pick-Up Arrangements**

1. I hereby authorize the following, to pick up the participant each day. If there are any changes in these arrangements, I will let the program staff know (in writing) in advance.

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Relationship to participant:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Relationship to participant:** \_\_\_\_\_

2. Is the participant permitted to walk home at the end of the program each day? Yes \_\_\_\_\_ No \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_

**Health Information**

**Family Doctor:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Does the participant have a disability or require support?** Yes \_\_\_\_\_ No \_\_\_\_\_

*If yes, please specify and include any information our staff may need to know by answering the questions on the Inclusion Support Information Sheet.*

**Medication/Allergies**

1. Does the participant require medication? Yes \_\_\_\_\_ No \_\_\_\_\_

*If yes, please explain:* \_\_\_\_\_

2. Do you require medication to be administered or stored by staff during the program? Yes \_\_\_\_\_ No \_\_\_\_\_

*If yes, please fill in the required medical forms.*

3. Does the participant have any allergies? (Food/drug/environmental) Yes \_\_\_\_\_ No \_\_\_\_\_

*If yes, please indicate each and the treatment required:* \_\_\_\_\_

4. Does the participant have a life-threatening allergy? (Anaphylaxis) Yes \_\_\_\_\_ No \_\_\_\_\_

5. Does the treatment for this allergy involve the use of an EpiPen®? Yes \_\_\_\_\_ No \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_

**Authorization**

1. I authorize staff to secure medical advice and services, as deemed necessary, for the health and safety of the participant.

**Parent/Guardian Signature:** \_\_\_\_\_

2. I have read, understood, and discussed the *Program Behaviour Policy and Procedures* with the participant(s).

**Parent/Guardian Signature:** \_\_\_\_\_

3. I have completed the Photo Release Form.

**Parent/Guardian Signature:** \_\_\_\_\_

*If the participant requires Recreation Programming Staff to administer and/or store medication (prescription and/or non-prescription), please obtain the necessary medical forms online at [www.halifax.ca/rec/forms](http://www.halifax.ca/rec/forms) or from your Community Recreation Centre. Completed Medical forms are required and to be returned to the Community Recreation Centre prior to the start of the program.*

*In accordance with Section 485 of the Municipal Government Act (MGA), the personal information collected on this form will only be used by HRM staff and, if necessary, individuals under service contract with HRM for purposes relating to recreation program administration. If you have any questions about the collection and use of this information, please contact HRM's Access and Privacy Office at 902-490-4390 or [accessandprivacy@halifax.ca](mailto:accessandprivacy@halifax.ca)*