



CITY OF LAS VEGAS

AFTER SCHOOL PROGRAM



CLERK SIGNATURE: _____

DATE: _____

AMOUNT PAID: _____ PAYMENT TYPE: _____

PARENT SIGNATURE: _____

DATE: _____

SECURITY

CITY OF LAS VEGAS RECREATION DEPARTMENT

PICK UP AUTHORIZATION FORM

I/We, _____ the parent(s)/guardian(s) of
_____ give permission for the
following individuals to pick-up my child/children from the Recreation
Department in my absence:

Name

Phone

1. _____
2. _____
3. _____
4. _____
5. _____

Parent/Guardian

Date

Recreation Representative

Date

CITY OF LAS VEGAS RECREATION DEPARTMENT
INTERNET/COMPUTER USER AGREEMENT RULES

1. User/s must be registered in a youth program provided by the Recreation center.
2. Users may not store data on any computer hard drive located at the facility.
3. No food or drink is allowed in the computer room.
4. User is expected to be familiar with computers.
5. The Recreation Center will provide adequate staff to be available for consultation or instruction on computers. Any problems are to be reported immediately to a staff member.
6. All costs incurred during the course of Internet/Computer use are the responsibility of user.

_____ I have read and agree to abide by the Internet/Computer Agreement Rules.
I will take proper care of all equipment, manuals and books that are the property of the City of Las Vegas Recreation Department. No materials that are used in the computer classroom will be removed from the Recreation Center.

_____ I agree to observe all copyright laws and not duplicate any software or documentation that may be protected by such laws.

_____ Failure to observe any part of this agreement may result in the termination of using the computers.

Student Signature

Date

Parent Signature

Date

I/We, named below do hereby agree to release, hold harmless, and forever give up any claim against the City of Las Vegas Recreation Dept. or any of its agents or representatives, that may arise in the future, for damages on account of bodily injury or property damages arising in any manner out of participation in the Abe Montoya Recreation Centers programs.

I/We, understand that should any injury occur during participation in the aforementioned programs, the City of Las Vegas, its agents, and/or its representatives cannot be held responsible; and I/We, understand that by signing this form all legal rights to hold the City of Las Vegas Recreation Dept. or any of its agent or representatives responsible are waived.

Parent/Guardian Signature Date

Parent/Guardian Signature Date

****The City of Las Vegas Recreation Department does not have the ability to handle special needs children, if your child has special needs they will need to be accompanied by someone who is able to care for their individual needs.**

Parent/Guardian Signature Date

Parent/Guardian Signature Date

CITY OF LAS VEGAS EMERGENCY MEDICAL AUTHORIZATION FORM

Purpose: To enable parents/guardians to authorize emergency treatment for children who become ill or injured while under program authority, when parents cannot be contacted? Upon completion parents must return this form to the Abe Montoya Recreation Center. The original form and any copies thereof may be used to identify the medical options of the undersigned parent/guardian.

Participant's Full Name

D.O. B.

Mother's Full Name

Daytime Phone

Father's Full Name

Daytime Phone

GRANTING CONSENT

In case of an emergency involving my child where I cannot be reached, I hereby give my consent to transport my child to the following medical care providers, I give any reasonable and customary medical and health care deemed necessary.

Primary Physician

Phone #

Primary Dentist

Phone #

If for any reason the above listed medical care providers cannot be reached, I authorize appropriate transport and medical care of my child to any appropriate medical care provider, hospital, and/or medical facility. This authorization does not cover any major surgery unless one other doctor/dentist concur. Nothing in this section shall be constructed to impose liability on any city official or city employee whom in good faith, attempt to comply with this section. It is understood that I will be financially responsible for all emergency care.

Parent/Guardian Signature

Date

MEDICAL HISTORY

Facts concerning the child's medical history to which a physician should be alerted.
All information obtained is considered confidential, except to medical provider.

Please indicate if the participant has had, or is currently under treatment for any of the following conditions:

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ear Problems |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Tetanus (Date) | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Muscular Weakness | <input type="checkbox"/> Allergies |

Reactions to Medicines _____

Hospitalized serious illness, surgery, or accidents? Explain:

Use of Contact Lenses? Yes No

Long Term Medications? _____

Have you ever been treated or informed of the need to be on an antibiotic therapy prior to dental treatment? Yes No

Please add any problems not listed: _____

COMMENTS: _____

******* Attach a copy of immunization record*******