Live Wires & Sparks Information Sheet

Child's Name:	**Birth Date: / /**	**Age:**
Parent(S)/Guardian(S)		
1. Name	Birthdate: / / Relationship To Child	
Address	Email	
Home Phone	Cell #	Work #
2. Name	Birthdate: / / Relationship To Child	
Address	Email	
Home Phone	Cell #	Work #

List up to 3 additional people that are allowed to pick up your child from camp.
Please notify the people listed their photo ID is required when picking up your child.

Persons Authorized To Pick Up Child	Relationship To Child	Phone Numbers
1.		
2.		
3.		

Emergency Contact Person(S)		
1. Name	Relationship To Child	
Home Number	Cell Number	Work Number
2. Name	Relationship To Child	
Home Number	Cell Number	Work Number

In the event my child needs medical treatment, I hereby authorize treatment of the above named minor by a qualified and licensed health care professional. This authorization is valid only after reasonable effort has been made to contact me.

Physician Name	**Dentist Name**
Phone Number	Phone Number
Address	Address

Medical Information		
Medications		
Medication	Dosage	Frequency
Allergies		
Name Of Allergy	Reaction	Treatment Needed

Medical Information, Continued		
Is the participant subject to seizures?	☐ **Yes**	☐ **No**
If Yes, Is there a specific cause?		
Type	**Frequency**	
Are seizures controlled by medications?	☐ **Yes**	☐ **No**
In the event a seizure happens at camp please list our steps to take? (ie. Call 911, Give Meds, Allow to rest & Call parents)		

Are there any doctor's restrictions?	☐ **Yes**	☐ **No**
If Yes, please describe:		
Does the participant use/wear any of the following devices?		
☐ **Glasses**	☐ **Orthopedic Devices**	☐ **Prosthesis**	☐ **Hearing Aid**
Other:		

DIETARY NEEDS		
Does the participant have any special diets or dietary restrictions?	☐ **Yes**	☐ **No**
If Yes, please explain:		

SAFETY		
Please indicate Yes or No to the following:		
Willing to stay with the group?	☐ **Yes**	☐ **No**
Can recognize danger?	☐ **Yes**	☐ **No**
Able to say name & phone number?	☐ **Yes**	☐ **No**
May wander or run?	☐ **Yes**	☐ **No**

PERSONAL CARE		
Does participant need assistance in the bathroom?	☐ **Yes**	☐ **No**
If yes, how?		
Are regular bathroom times needed?	☐ **Yes**	☐ **No**
If Yes, when?		

BEHAVIOR/PERSONALITY		
Describe the best way to get the participant involved in an activity:		
Does participant have fears or phobias?	☐ **Yes**	☐ **No**
If Yes, please describe:		
Are there any settings or activities that might cause behavior difficulties (noises, airplanes, escalators, flashing lights, etc.)?		
What is the best way to redirect the participant?		
What type of behavior management or reinforcement works best?		
Interests/Hobbies		
Please give us any additional information that you feel would help us to better serve your child. The information you provide is a vital part of us giving your child the best experience we can.		