Sylvania Recreation

Summer Days Camp Release Form - 2026

Participant Name: ____________________________________ **DOB:** ____________ **26/27 Grade:** __________

Parent/Guardian Name(s): ____

I certify that ______________________________, as the parent/guardian of __________________________, give my consent to Sylvania Recreation and its medical representative to obtain medical care from any licensed physician, hospital, or clinic for the above mentioned participant for any injury that could arise from the participation of the Summer Days Camp sanctioned events. I authorize that he/she will participate in all sanctioned Sylvania Recreation activities or events. These activities or events include, but are not limited to, sports, art/crafts, traveling with the camp on a bus to and from that day's field trip location, and walking to and from scheduled activities. I understand that SRC staff may take digital images or video to use for promotion of programs and events on websites, commercials, or other promotional materials. I fully permit SRC use of any images of me/my child(ren) and waive any claim for such use.

Parent/Guardian Signature: ____Date**:** ____________________

If said participant is covered by any insurance company, please complete the following:

Insurance Company: ____

Policy Number: ____

Parent/Guardian Signature: _______________________________________ **Date:** __________________

Medical History

Please describe any problem and its complications for proper first aid treatment on the back of this form. *

Head Injury	☐	Hernia	☐	Allergies	☐	____________________________________
Asthma	☐	Heart Murmur	☐			____________________________________
Diabetes	☐	Neck/Back injury	☐	Other	☐	____________________________________
Fainting Spells	☐	Epilepsy	☐			____________________________________

Does your child currently take any medications? If yes, please list all medications being taken below.

____

____

____

Has a doctor placed any restrictions on your child's activity? **Yes** **or** **No**

Emergency Contact Information

Name: ____ **Relation:** _______________________ **Phone:** _________________

Email Address: ____

Name: ____ **Relation:** _______________________ **Phone:** _________________

Email Address: ____

Child's School: ______________________________________ **Resident of Sylvania? Yes or No**

Child's Home Address: ____

Hospital of Choice: ____

Other Authorized Pick-Up Contacts

Name: __________________________________ **Relation:** ______________________ **Phone:** _______________________

Name: __________________________________ **Relation:** ______________________ **Phone:** _______________________

Name: __________________________________ **Relation:** ______________________ **Phone:** _______________________

*Medical History Continuation

____

____

____

____

____

____

____

____

____

____

____

____