



**Camp Fire USA Out of School Programs**

Child's Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Male  Female   
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_

**Parent / Guardian Contact Information**

Parent /Guardian 1  
Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Work Phone \_\_\_\_\_ Email \_\_\_\_\_

Parent /Guardian 2  
Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Work Phone \_\_\_\_\_ Email \_\_\_\_\_

Please select the school your child attend and type of enrollment:

Caesar Chavez Elementary  Springdale Elementary   
Diamond Hill Elementary  Oakhurst Elementary   
Dolores Huerta Elementary  M. H. Moore Elementary   
H.V. Helbing Elementary   
Bonnie Brae Elementary   
Child's Current Grade \_\_\_\_\_



The following persons are authorized to pick up my child:

Name \_\_\_\_\_ Drivers License Number \_\_\_\_\_

Name \_\_\_\_\_ Drivers License Number \_\_\_\_\_

Name \_\_\_\_\_ Drivers License Number \_\_\_\_\_

It has been mandated through court order that the following person's are not allowed to pick up my child  
(Please provide on site staff with copies of court documents):

Name \_\_\_\_\_ Name \_\_\_\_\_

Emergency Medical Care

Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Dentist \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Hospital \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_



In order for Camp Fire to provide the best possible experience for your child, please let us know of any special needs: (Continue on back and/or attach additional pages if needed)

Emotional \_\_\_\_\_ Physical \_\_\_\_\_

Mental \_\_\_\_\_ Behavioral \_\_\_\_\_

Please list any known allergies \_\_\_\_\_

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Please list any medication your child is currently taking \_\_\_\_\_

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Please select the following that pertain to your child:

ESL

Speech Therapy

Vision / Hearing Difficulty

Asthma

Diabetes

Obesity

Special Dietary Needs

Please specify: \_\_\_\_\_

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Neurological Disorders

Please specify:

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Please list all significant surgeries your child has had:

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Number in Household \_\_\_\_\_

Number of Adults \_\_\_\_\_ Number of Children \_\_\_\_\_

Ethnicity

African American

Asian

Caucasian

Hispanic

Native American

Other (Please specify) \_\_\_\_\_

Household Income

Below \$17,000

\$17,001 - \$35,000

\$35,001 - \$50,000

Over \$50,000

Do you work on Saturday's? Yes  No

If yes, what hours do you typically work? \_\_\_\_\_



Child's Name: \_\_\_\_\_

Please identify which school your child attends:

- |  |  |   |
|--|--|---|
| <input type="radio"/> Caesar Chavez Elementary<br>3710 Dean Rd.<br>Fort Worth, TX 76106<br>817-378-5000              | <input type="radio"/> Springdale Elementary<br>3207 Hollis St.<br>Fort Worth, TX 76111<br>817-815-0400 | <input type="radio"/> Diamond Hill Elementary<br>2000 Dewey St.<br>Fort Worth, TX 76106<br>817-814-9600 |
| <input type="radio"/> Dolores Huerta Elementary<br>3309 W. Long Ave.<br>Fort Worth, TX 76106<br>817-814-4400         | <input type="radio"/> H.V. Helbing Elementary<br>3524 N. Crump<br>Fort Worth, TX 76111<br>817-815-0500 | <input type="radio"/> Bonnie Brae Elementary<br>3504 Kimbo Rd.<br>Fort Worth, TX 76111<br>817-222-7500  |
| <input type="radio"/> M. H. Moore Elementary<br>1809 NE 36 <sup>th</sup> St.<br>Fort Worth, TX 76106<br>817-815-0600 |  |   |

I certify that my child's immunization record is current and on file at the above identified school.

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date



**To the parent or guardian of this participant, your signature below indicates the following:**

- My child has permission to take part in all activities, including field trips and water activities, unless noted below.
- I give my permission for my child to be photographed and/or videotaped by Camp Fire USA and other organizations or individuals approved and accompanied by Camp Fire USA for purposes of advertising, public relations and family enrichment.
- I understand that for the safety of my child and others the following are grounds for dismissal from Camp Fire USA programs without a refund: possession and/or use of alcohol, drugs, tobacco, knives, fireworks, firearms and/or unmanageable and/or abusive behavior.
- As parent/legally authorized representative of the above named child, I am by this document representing that I have the authority to consent to all medical/surgical care and treatment of my child. I hereby give my authorization and consent for staff members from Camp Fire to consent to the medical/surgical care and treatment of my child at my expense, including taking my child to an emergency room. It is my intent that this authorization shall apply to immunizations, as well as other medical/surgical treatment and that this authorization is in effect while my child is participating in the Camp Fire USA program.
- I understand that reasonable measures will be taken to safeguard the health and safety of each child and I will be notified as soon as possible in case of an emergency. However, in the event of sickness or accident I will not hold the Camp Fire USA First Texas Council or the staff of Camp Fire USA First Texas Council and will release them from liability.
- Staff may search youth's belongings with the youth present when the health, well being, or safety of the camper or others deems it necessary.
- A faxed copy of this consent shall be as valid as the original for the health care provider, if necessary.
- **My child may participate in all activities except:**

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Parent / Guardian Signature

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Date

**AUTHORIZATION FOR EMERGENCY MEDICAL CARE**  
**AUTORIZACION PARA ATENCION MEDICA DE EMERGENCIA**

**If I cannot be reached to make arrangements for emergency medical care for my child at the time of an illness or accident, I give my permission for:**

Si en caso de alguna enfermedad o accidente no me pueden localizar para arreglar atención médica de emergencia para mi niño, doy permiso para que:

<b>Name of Day Care Facility Owner or Director</b> Nombre del Dueño o Director del Centro de Cuidado de Niños
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**to take my child (or children):**

a que lleve a mi niño (o mis niños):

<b>Name of Child (1)/Nombre del Niño (1)</b>	<b>Name of Child (2)/Nombre del Niño (2)</b>
<b>Name of Child (3)/Nombre del Niño (3)</b>	<b>Name of Child (4)/Nombre del Niño (4)</b>

**to:**

a:

<b>Name of Doctor/Nombre del Doctor</b>	<b>Telephone No./Teléfono</b>
<b>Address of Doctor/Dirección del Doctor</b>	

**or to:**

o a:

<b>Name of Hospital or Clinic/Nombre del Hospital o Clínica</b>	<b>Telephone No./Teléfono</b>
<b>Address of Hospital or Clinic/Dirección del Hospital o Clínica</b>	

**I give consent for necessary emergency treatment when my child is in the care of this physician or hospital or clinic.**

Doy mi consentimiento para el tratamiento médico necesario estando mi niño bajo la atención de este doctor u hospital o clínica.

\_\_\_\_\_  
**Signature-Parent or Legal Guardian**  
Firma-Padre o Tutor

\_\_\_\_\_  
**Date/Fecha**