

SUMMER CAMP NOW & THEN

Get ready for a summer of fun! Games, Swimming, Field Trips, & More!

7:30AM - 5:30PM

5 - 12 YRS

MAY 28 - AUGUST 2

NO CAMP JUNE 19, JULY 3 - 5

\$25.00 PER DAY OR \$100.00 PER WEEK LINCOLN CENTER | 710 W 9TH ST.





FOR MORE INFO

620.231.8310 710 W 9th St. CCL 010 Rev. 5/2020 Kansas Department of Health and Environment Bureau of Family Health 1000 SW Jackson, Suite 200 Topeka, KS 66612-1274



Child Care Program: (785) 296 -1270 Fax: (785) 559-4244 Website: www.kdheks.gov/kidsnet

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

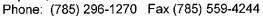
		License #
Lincoln Center		0078350-005
I authorize Pittsburg Parks and Recreation		(caregiver/staff) who
is (are) representative(s) of the above-named facility to give co		
youth(child between 08/14/2023 and 08/16/2024	·	or youth is in the facility's custody
MM/DD/YYYY MM/DD/YYYY		
Is child covered by health insurance? ☐ Yes ☐ No		
If yes, complete the following: Health Insurance Policy Name	Polic	y Number
Medical Assistance Program	Ca	rd Number
Military Medical Care I.D. Number		
If known, date of last Tetanus inoculation:MM/D		
MM/D	D/YYYY	
List any known allergies or other information about the me	edical conditions of this child or	youth pertinent in case of emergency:
P		
Signature of Parent or Guardian		Date Signed
Witness to Parent's or Guardian's signature if required b	v the local hospital or clinic.	Date Signed
J	,	
Notarization of Parent's or Guardian's signature if require	d by local hospital or clinic.	
State of Kansas	d by local hospital or clinic.	
State of Kansas		
State of Kansas County of	by	
State of Kansas County of Signed or attested before me on MM/DD/YYYY	by	
State of Kansas County of Signed or attested before me on	by	
State of Kansas County of Signed or attested before me on MM/DD/YYYY	by	son
State of Kansas County of Signed or attested before me on MM/DD/YYYY	byName of Per Name of Per Signature of notarial office	son
State of Kansas County of Signed or attested before me on MM/DD/YYYY	byName of Per	son

The Medical Record/Assessment Form (Or Health Status History form for School Age Programs) and the authorization for Emergency Medical Care must be taken to the emergency room. Both forms must also be in a vehicle when the child or youth is transported by the facility.

CCL. 358 Rev. 5/2020

Kansas Department of Health and Environment

Bureau of Family Health Child Care Licensing Program 1000 SW Jackson, Suite 200 Topeka, KS 66612-1274



Website: www.kdheks.gov/kidsnet



HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

ompl	le <u>te on</u>	e form	for each child or youth attending	the School	Age Prog	ram.	
First a	and Las	t Name	of the Child or Youth		Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)
First a	and Las	t Name	of the Child's or Youth's Mother or G	uardian			
Mothe	er/Guar	dian's H	lome Street Address	City		Zip Code	Home Phone #
Viothe	er/Guar	dian's V	Vork Place Name & Street Address	City		Zip Code	Work Phone #
irst a	and Las	st Name	of the Child's or Youth's Father or G	uardian			
Fathe	r/Guare	dian's H	ome Street Address	City		Zip Code	Home Phone #
Fathe	r/Guare	dian's W	ork Place Name & Street Address	City		Zip Code	Work Phone #
Name	s and a	iges of d	other children in the Child or Youth's	Family (Atta	ch addition	al page if needed	.)
case Stree	of eme	rgency.	d to pick up the Child or Youth in Include first and last name and ach additional page if needed.	City		Zip Code	Phone Number (during program hours):
2. 3.							
First	and La	st Name	of Physician & Street Address	City		Zip Code	Phone Number
Name	of Hos	spital Pr	reference in case of emergency.				1,
Yes	No	N/A	Complete the following information	n about medi	cations for	this child or yout	h.
		-	Will this child or youth need to take an program?	ny nonprescri	ption or pres	cription medicatio	n during their time at the
			If yes above, is there signed permissi	ion on file?			-

Allergies	Frequent sore throats/ colds	Ear Infections or Aches	Heart or Lung Conditions
Skin Problems	Asthma	Headaches	Diabetes
Vision	Speech/Communication	Hearing	Emotion/Behavior

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.

Complete the following information about this child's or youth's immunization status.

Yes	No	
		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
		If yes, are this child's or youth's immunizations current?
\times		If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

riease giv	e dates in the space below for ALL immunization serie	s completed	Jy tilla cilli	a or youth.	TCCCOTA IIII	11/00/1111.
		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	1 1	11	1 1	1 1	1 1
	POLIO	1 1	1.1	11	11	
	MMR	1 1	1 1			<u> </u>
Single	RUBEOLA (MEASLES)	1 1	1 1	1		
Dose						
Only	~		<u> </u>	_		
1	MUMPS	/ /	1 1			
	RUBELLA (GERMAN MEASLES)	1 1	1 1			
	HIB (Hemophilus Influ. B) *RECOMMENDED	1 1	1 1	1 1	1 1	1
	HBV (Hepatitis B Vaccine) *RECOMMENDED	1 1	11	1 1		_
	VAR (Varicella-Chicken Pox) *RECOMMENDED	1 1			_	

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed
If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person the child/youth?	•

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form

Date Signed

RELEASE

vame of Participant:	
n consideration of the use of my likeness, and for other good and valuable consideration herein acknowledged as received, I hereby grant, in perpetuity, to Pittsburg Parks and Recreation., its successors and assigns, exclusive authority ar permission as follows:	nd
perpetually and irrevocably give Pittsburg Parks and Recreation, my consent and authorization to take photos of my child to use for promotion of Camp Now and Then on all Pittsburg Parks and Recreation Social Media sites or other printed materials.	Ė
waive any right to see or approve any recording of my likeness and any material in which my likeness is used. I agree and understand that my likeness may be modified or distorted and that my own name, a fictitious name, or no name may used in association with my likeness. I irrevocably release, discharge, and hold Pittsburg Parks and Recreation, from an claims, demands, or causes of action that I may now have or may hereafter have defamation, slander, libel, invasion of privacy or right of publicity, copyright infringement, or any other right arising out of or relating to the use of my likeness	be y for
By signing this Release, I agree and represent that I can enter this contract in my own name, that I have read this Release and fully understand its contents, and the this Release shall be binding upon me and my heirs, legal representatives, and assigns.	at
If the Participant is Under the Age of 18 Years: I warrant that I am the parent or legal guardian of the above-named person (the "Participant"), and I irrevocably consent to and authorize all of the foregoing on behalf of Participant and myself.	
Name of Parent/Legal Guardian:	
Signature:	_

CCL. 034 Rev. 3/2020

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 Fax: 785-559-4244



Website: www.kdheks.gov/kidsnet



PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as state	d on the license)				Lice	ense #	
Lincoln Contor					007	8350-005	
Lincoln Center		City		Zip Code	51/51/20	County	
Street Address of the Facility		City		Zip Code		County	
710 W 9th St	10 W 9th St			66762	Crawford		
	may	go to the followir	na locations	off the pred	mico	with adul	t cupanticion:
First and Last Name of Child or		go to the following	ig locations	on the prei	111150	s with audi	it supervision.
Place	Street Address		City		Ву \	/ehicle	Walk/Bike
Lincoln Park	813 Memoria	I Dr.	Pittsburg				Walk
Signature of Parent or Guardian					Date	e Signed	
Place	Street Address		City		Ву \	Vehicle	Walk/Bike
Pittsburg Aquatic Center	708 W 9th S	St.	Pittsburg]			Walk
Signature of Parent or Guardian					Date	e Signed	1
Diago	Street Address		City		D./ N	Vehicle	Walk/Bike
Place Crawford County Museum	651 S Hwy 6		Pittsburg			i & Car	VValk/Dike
Signature of Parent or Guardian	1001 0 11Wy 0	<u> </u>	i ittoburg			e Signed	
Signature of Farent of Guardian					Dut	o orginou	
		17					_
Place	Street Address		City			Vehicle	Walk/Bike
Westside Elementary	430 W 5th S	St .	Pittsburg	3		n & Car	
Signature of Parent or Guardian					Date	e Signed	
Place	Street Address	S	City		Ву	Vehicle	Walk/Bike
House of Bounce	3684 N Main	St Rd	Joplin		Bus	3	
Signature of Parent or Guardian	•		•		Date	e Signed	*
Place	Street Address	s	City		By	Vehicle	Walk/Bike
Wonders Of Wildlife National	500 W Suns		Springfie	eld	Bus		
Museum & Aquarium Signature of Parent or Guardian	Tool II Gain	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	100			e Signed	
						- Allendering	
					-		
[la		100		I .	V-1-1-	Manual Piles
Place	Street Addres	S	City		By,	Vehicle	Walk/Bike
Simple of Parantan Consultan				-	Dat	o Cianad	
Signature of Parent or Guardian					Dat	e Signed	

Parent and Camp Now & Then Agreement

I have read and understand the enclosed policies and regulations listed in the 2024 Summer City of Pittsburg Camp Now & Then Parent Handbook. I understand these policies and agree to follow them. Including: (Please initial each area)

2024 Program Dates		
Enrollment		
Withdrawal Procedures		
Temporary Withdrawal Policy		
Registration and Fees		
Absences Policy		
Health, Illness, and Medication Policies		
Toys and Personal Items Policy		
Camp Code of Conduct		
Clothing Policy		
Family Custodial Matters Policy		
Parent Involvement Policy		
Parent or Guardian Signature	Date	
Pittsburg Parks and Recreation Staff Signature	 Date	

Pittsburg Parks and Recreation 710 W 9th St. Pittsburg, KS 66762 620-231-8310 pprd@pittks.org

Camp Now & Then Payment Plan Agreement Bi-Weekly

Parent/Guardian Name:	<u> </u>	Date:	-
Phone Number:			
Address:			_
City:	State:	Zip Code:	_
Email:			_
Child(ren) Name(s):			_
amounts stated on the payl understand the penalty and agreement is violated. The from Camp Now & Then Pro	ment schedule be d charges that will penalties include a ogram, possibility gram, and househ	ents on the specified dates and the agelow to Pittsburg Parks and Recreation be assessed to the household accou applying fees to account, child(ren) sure of individual or household being remoded members suspended from partic	n. I nt if the uspended noved from
Total amount owed (beginr	ning balance)	\$	-

Payment Date	Payment Amount	Balance
05/24/24		
06/07/24		
06/21/24		
07/02/24		
07/19/24		
07/26/24		

I agree that the above schedule of payments is an acceptable payment plan for the total amount for the Camp Now & Then Program and will keep household account current.

Parent/Guardian Signature	Date

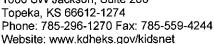
Camp Now & Then Payment Plan Agreement Monthly

	Date:
State: Zip Code:	
t schedule below to Pittsburg Par orges that will be assessed to the lastices include applying fees to accomm, possibility of individual or hou or and household members suspe Programs.	ks and Recreation. I household account if the ount, child(ren) suspended sehold being removed from nded from participation in
Payment Amount	Balance
	make payments on the specified t schedule below to Pittsburg Pararges that will be assessed to the alties include applying fees to accom, possibility of individual or hour, and household members suspe Programs.

CCL.026 Rev. 5/2020

Kansas Department of Health and Environment

Bureau of Family Health Child Care Licensing Program 1000 SW Jackson, Suite 200 Toppka, KS 66612-1274





Authorization for Dispensing Medications to Children and Youth Short-Term Medications (Prescription and Non-Prescription)

<u>Prescription medication</u> must be in their original containers labeled with the child's/youth's first and last name; the name of the licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) who ordered the medication; the date the prescription was filled; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication. Administer the medication only to the child/youth designated on the prescription label in accordance with the instructions on the label. <u>Non-prescription medications</u> can be given with written permission and direction from the parent or legal guardian. Administer nonprescription medication from the original container labeled with the first and last name of the child/youth and according to the instructions on the label.

Medication #1	Medication #2
First and Last Name of Child/Youth Date of Birth	First and Last Name of Child/Youth Date of Birth
Name of Medication	Name of Medication
Reason for Medication	Reason for Medication
Dose Time to be Given Stop Date	Dose Time to be Given Stop Date
Name of Licensed Physician/PA/APRN prescribing the medication () Phone Number of Physician, PA, or APRN I allow the above medication to be given to my child/youth by the designated person.	Name of Licensed Physician/PA/APRN prescribing the medication () Phone Number of Physician, PA or APRN I allow the above medication to be given to my child/youth by the designated person.
Parent's Signature Date	Parent's Signature Date

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE. Designated Person to note any comments or remarks about the child's/youth's appearance on the back of this form. *Each designated person administering medication is to sign on the back side of this form and identify initials used.

Date mm/dd/yy	Time	Name of Medication	*Initials	Date mm/dd/yy	Time	Name of Medication	*Initials
		-					
						<u></u>	
				···			
						_	

*Signature of Designated Person Administering Medication		Initialing as		
*Signature o	of Designated Person Administering Medication	Initialing as		
*Signature o	of Designated Person Administering Medication	Initialing as		
*Signature	of Designated Person Administering Medication	Initialing as		
	Note Form			
		Later I have been been been been been been been be		
Date	Additional comments about the incident or other comments or remarks about the child's/youth's a	related incidents, including appearance and/or condition.		
	-			
				
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