



## Participant Information

Indicate below any information you feel would benefit Carol Stream Park District staff. Lack of detailed information compromises the staff's ability to successfully accommodate your child. Carol Stream Park District is not responsible for any injuries, complications, damages or losses due to lack of information provided. Many resources and adaptations are available to assist your child; please keep us informed.

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

**ONE PARTICIPANT PER FORM**

Parent's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Are immunizations up to date?  Yes  No \_\_\_\_\_

### Allergies/Dietary Restrictions

### Medical Concerns & Medications

If your child has medication that may need to be administered by Carol Stream Park District staff or medication that may be self-administered (including asthma inhalers), a Permission to Dispense Medication Form must be completed.

### Behaviors, Fears & Miscellaneous

Yes, child has special needs or need one-on-one assistance.

If yes, provide details. Note that one-on-one aides must be requested at least two weeks in advance.



Parents/Guardians with custody have authorization to pick up the participant. List siblings, parents without custody, relatives, or friends who are also authorized to pick-up your child. All individuals must present a photo ID in order for your child to be released into their custody. Only the custodial parent(s) may approve additions or changes to the Authorized Contact and Release List.

**Child Information** ONE PARTICIPANT PER FORM

Child Name	Birthdate	Age	M/F

**Parent/Guardian** Name \_\_\_\_\_ Relationship \_\_\_\_\_

Email \_\_\_\_\_ Cell \_\_\_\_\_ Add'l Phone \_\_\_\_\_

**Parent/Guardian** Name \_\_\_\_\_ Relationship \_\_\_\_\_

Email \_\_\_\_\_ Cell \_\_\_\_\_ Add'l Phone \_\_\_\_\_

Do both parents have custody?  Yes  No

**Address** Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Authorized Contacts**

Minimum of one authorized person other than the child's parent/s must live within five miles of the program.

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

**NOT AUTHORIZED TO PICK UP**

Name \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_

I authorize the Carol Stream Park District to release my child to the above listed persons in the event that I am unable to pick up my child myself. I release the Carol Stream Park District from any and all responsibility once my child has been released into the custody of these above individuals.

INTERNAL USE ONLY

\_\_\_\_\_  
STAFF INITIAL      \_\_\_\_\_  
DATE

**Parent/Guardian Name** (Print)

\_\_\_\_\_

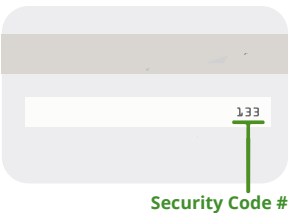
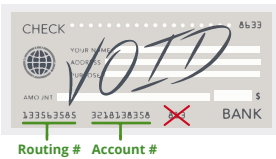
**Parent/Guardian Signature**      **Date** MM/DD/YY

\_\_\_\_\_

**Enrollment For**

- ActivKids**
- Camp**
- Dance**
- Fitness**
- Forever Young**
- Preschool**
- Springers**
- Other**

Payments for the following programs are due throughout the duration of the program or membership contract. Review your program's specific payment guidelines for details.



Participant Name \_\_\_\_\_

 Organization Name *(if applicable)* \_\_\_\_\_

Cell Phone \_\_\_\_\_ Add'l Phone \_\_\_\_\_

**ECP Authorization** *(electronic check withdrawal from checking account)*

Account Holder's Name \_\_\_\_\_

Routing # \_\_\_\_\_

Account # \_\_\_\_\_

**I hereby authorize the Carol Stream Park District to process my monthly program fees by way of electronic check payment.**
**Debit/Credit Card Payment Authorization**

- Debit Card
- Credit Card
- Business Card

*Business Card must include name of user or be accompanied by company letter of authorization that can be verified by phone.*

Card Holder's Name \_\_\_\_\_

 Card Number *(last 4 digits)* \_\_\_\_\_

Expiration Date \_\_\_\_ / \_\_\_\_

Security Code # \_\_\_\_

**I hereby authorize the Carol Stream Park District to process my monthly program fees by way of debit/credit card.**
**TERMS OF AUTOMATIC PAYMENT PLAN**

My payment amount is outlined in my program's payment structure, and may fluctuate if I change my program registration in any way. **The start and end dates of this scheduled payment will follow the terms outlined in my program's payment guidelines and will be processed based on the program's specific payment plan.** Declined payments will be reprocessed for up to 10 business days.

I agree to maintain sufficient funds in my bank account or credit card account to cover each payment. I understand that if I choose to cancel my payment, it must be requested in writing 5 days prior to my next payment and I must make alternate payment arrangements. Any EZ Payment that fails to process will be assessed a non-sufficient funds fee, and may result in the forfeiture of the EZ Payment option. CSPD reserves the right to change or revoke the payment plan, or an individual's participation in the payment plan or program, with or without notice.

**INTERNAL USE ONLY**

STAFF INITIAL \_\_\_\_\_

DATE    /    /

Payment Plan Updated

**Name (Print)** \_\_\_\_\_

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**Signature** \_\_\_\_\_ **Date MM/DD/YY** \_\_\_\_\_

**RETURN BY EMAIL: INFO@CSPARKS.ORG**
**RETURN BY MAIL: CAROL STREAM PARK DISTRICT 849 W. LIES RD. CAROL STREAM, IL 60188**