PERSONAL INFORMATION RECORD

PROGRAM NAME	COURSE CODE	START DATE

A. PARTICIPANT INFORMATION

NAME (LAST NAME, FIRST NAME)

PHONE # (XXX-XXX-XXXX) | DATE OF BIRTH (MM/DD/YY)

1. A) LEGAL PARENT/GUARDIAN NAME (LAST NAME, FIRST NAME) | B) LEGAL PARENT/GUARDIAN PHONE # (XXX-XXX-XXXX)

2. A) LEGAL PARENT/GUARDIAN NAME (LAST NAME, FIRST NAME) | B) LEGAL PARENT/GUARDIAN PHONE # (XXX-XXX-XXXX)

ATTACH PHOTO HERE
(as required)

Note: By providing legal parent/guardian name you are confirming that person(s) listed can be contacted regarding the participant's health and to be picked up from program

B. EMERGENCY CONTACT INFORMATION *(in the event parent/guardian cannot be reached. Must be 18 years of age or older)*

NAME (LAST NAME, FIRST NAME) | PHONE # (XXX-XXX-XXXX)

PLEASE INDICATE RELATIONSHIP OF THE EMERGENCY CONTACT TO THE PARTICIPANT: | **DOES THE EMERGENCY CONTACT HAVE PERMISSION TO PICK-UP PARTICIPANT?** ☐ YES ☐ NO

C. DESIGNATED PICK-UP PERSON INFORMATION *(in addition to emergency contact and parent or guardian)*

NOTE: PICK-UP PERSON(S) LISTED BELOW MUST BE AT LEAST 14 YEARS OF AGE OR OLDER

	NAME (LAST NAME, FIRST NAME)	PHONE # (XXX-XXX-XXXX)
1.		
2.		
3.		

D. MEDICATION INFORMATION

1. DOES THE PARTICIPANT HAVE ANY ALLERGIES OR MEDICAL CONDITION(S)? ☐ YES ☐ NO

IF YES, PLEASE LIST HERE OR ENTER N/A:

2. DOES THE PARTICIPANT REQUIRE AN AUTO-INJECTOR? ☐ YES ☐ NO

3. DOES THE PARTICIPANT REQUIRE AN INHALER? ☐ YES ☐ NO

Note: Please bring a minimum of one (1) inhaler and/or one (1) auto-injector if required

4. DOES THE PARTICIPANT REQUIRE MEDICATION TO BE ADMINISTERED BY STAFF? ☐ YES ☐ NO *IF "YES", COMPLETE THE "MEDICAL ADMINISTRATION FORM" ON FIRST DAY OF CAMP WITH A STAFF MEMBER*

5. PLEASE INDICATE IF THERE IS ANY OTHER SUPPORT INFORMATION REGARDING THE PARTICIPANT THAT YOU WOULD LIKE TO SHARE:

E. SUPPORT WORKER INFORMATION *(please complete the following where applicable)*

WILL THE PARTICIPANT BE ACCOMPANIED BY THEIR OWN PERSONAL SUPPORT WORKER? ☐ YES ☐ NO *IF "YES", COMPLETE SECTION AND SEE NOTE BELOW*

SUPPORT WORKER NAME (LAST NAME, FIRST NAME)	**PHONE # (XXX-XXX-XXXX)**	**FILE # FOR VSC STAFF USE ONLY**

Please note: *Anyone attending as a personal support worker (including family member or friend), must be 16 years of age or older, provide a valid Vulnerable Sector Check (VSC) dated within 3 months, attend program regularly with participant (no additional worker allowed within same week of program), wear PPE, provide contact information and participate in daily health screening as applicable (individuals that do not pass screening will not be permitted to enter or attend).*

I, the undersigned, hereby:

- Certify that the information recorded above is accurate and complete.
- Authorize City of Brampton staff to administer the above mentioned medication(s) to my child/dependent applicable to the timeframes and dosages identified.
- Acknowledge that any support workers I provide to assist the participant must be a minimum of 16 years of age and have a current and satisfactory Vulnerable Sector Police Record Check, to be presented to City of Brampton staff if requested.

Parent / Guardian Signature | *Date* (MM/DD/YY)

Date revised: 06/01/21

BRAMPTON Flower City
brampton.ca

MEDICATION ADMINISTRATION FORM

A. ADMINISTRATION INFORMATION

PROGRAM NAME	LOCATION
PARTICIPANT'S NAME (LAST NAME, FIRST NAME)	WEEK OF

NAME OF MEDICATION(S)	TIME MEDICATION IS TO BE ADMINISTERED	AMOUNT/DOSAGE TO BE ADMINISTERED

		MEDICATION NAME			
MONDAY	TIME				
	DOSAGE				
	ADMIN. BY				
	WITNESS BY				
TUESDAY	TIME				
	DOSAGE				
	ADMIN. BY				
	WITNESS BY				
WEDNESDAY	TIME				
	DOSAGE				
	ADMIN. BY				
	WITNESS BY				
THURSDAY	TIME				
	DOSAGE				
	ADMIN. BY				
	WITNESS BY				
FRIDAY	TIME				
	DOSAGE				
	ADMIN. BY				
	WITNESS BY				

Alternate formats available upon request, please email accessibility@brampton.ca or complete the Alternate Format Request form to submit your request

The personal information on this form is collected under authority of the Municipal Act SO 2001, c. 25. The information will be used to communicate with you regarding program administration and incidents requiring medical assistance. Questions about the collection of personal information should be directed to the Recreation Supervisor, Administrative Services; Community Services; Recreation; 2 Wellington St W; Brampton; ON; L6Y 4R2; 905.874.2705. Please review the City's Privacy Statement for more information.

Date revised: 06/01/21