Your son/daughter should function independently in the skills listed below, however, please provide any information you feel would be helpful to staff.

Grooming: Independent ____ Needs coaching ____ Other____
Toileting: Independent ____ Needs reminders ____ Bed wetting____
Sleep habits: Sleep walks ____ Talks in sleep ____
Usual bedtime _______ Usual wake up time _________

Does your son/daughter have unusual eating habits? ———
If yes, please describe: ______________________________________

Is this his/her first time away from home? Yes ____ No ____
Does your son/daughter have any motion sickness? Yes ____ No ____
Please list activities your son/daughter enjoys: (i.e. swimming, walking, amusement rides, shows, etc.) ____________________________________________
___________________________________________________________

Physical activity restrictions: __________________________________

Does your son/daughter have sun sensitivity? Yes _____ No ______
Do you give permission for your son/daughter to drink alcohol on this trip? Yes ____ No ____
If yes, how much? ________________________________________

If you will be away from home while your son/daughter is on this trip, please fill out the information below:
Location: _____________________________ Hotel or Home: ________
Address: _____________________________ Phone:__________________

Please attach a photocopy of the participant’s insurance card.
Health Information and History

Is your son/daughter subject to seizures?______ If so, please describe the type of seizure. After the seizures, how does he/she react?________________________________________________________

Frequent ear infections__________________________  Allergies (please check appropriate box)
Heart defect/disease______________________________ Penicillin __________
Diabetes__________________________________________ Insect stings __________
Bleeding__________________________________________ Other __________
Clotting disorders________________________________ Stomach problems __________
Fainting__________________________________________ Asthma __________

Date of last tetanus shot__________________________ Phone ______________________

Name of dentist/orthodontist_______________________ Phone ______________________
Name of family physician_________________________ Phone ______________________
Chronic or recurring illnesses______________________

Current Medication

Please list all prescriptions that will need to be taken on the trip as well as over-the-counter medications your son/daughter may take on the trip.

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Frequency/Dose per time</th>
<th>Dose per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________</td>
<td>-------------------------</td>
<td>--------------</td>
</tr>
</tbody>
</table>

Do you give the Orland Park Recreation Staff permission to dispense medication to your son/daughter on the trip?  Yes____ No _____ Signature________________________
If no, explain ________________________________________________________________

Medical Insurance Information

Name of insurance company __________________________
Address __________________________________________
Phone number_______________________________ Policy number __________________

If your son/daughter needs medical attention on this trip while in our care, do you give the group leader permission to take them to the hospital or physician?  Yes _____ No _____
Comments: ___________________________________________________________________

Signature: ___________________________________________________________________