PALS Data Form

This form can accommodate up to two (2) children.

PALS Participant Information

PALS Participant- Name	Gender	Birthdate
1.		
2.		

Address

City	State	Zip

Please check school your child(ren) will be attending:

❑ Elementary South
❑ Elementary North
❑ Aspen
❑ Townline/Dual Language
❑ Middle South
❑ Middle North

Parent/Guardian Information

Mother/Guardian 1 Information	Name:
Phone During PALS Hours:	Cell:
Place of employment:	Email:

Father/Guardian 2 Information	Name:
Phone During PALS Hours:	Cell:
Place of employment:	Email:

Emergency Contact

Emergency Contacts must be persons other than parents/guardians listed above.

Relationship:	Name:
Phone During PALS Hours:	Phone 2:

Relationship:	Name:
Phone During PALS Hours:	Phone 2:

Authorized Pickup Information

I give permission to the Vernon Hills Park District to release my child to the persons listed below.

Relationship:	Name:	Phone:
Relationship:	Name:	Phone:
Relationship:	Name:	Phone:

→

Medical & Health History

Please check all that apply. Include specifics where applicable.

<table>
<tr><th>Illnesses</th><th>Allergies – include specifics</th><th>Others/Special Needs</th></tr>
<tr>
<td>❑ Heart defect/disease
❑ Musculoskeletal disorders
❑ Bleeding/clotting disorders
❑ Type 1 Diabetes
❑ Type 2 Diabetes
❑ Seizures*
Please use space below to specify type and frequency of the seizures:

❑ Other*
Please use the space below to specify:</td>
<td>❑ Insect Stings

❑ Pollen

❑ Latex

❑ Medicine/Drugs

❑ Nuts

❑ Milk

❑ Food (Specifics)

❑ Others

Please explain type of allergy and severity of reaction:

Severe Allergies
Does your child require an:
❑ EpiPen
❑ Inhaler
If yes:
1. Parent must fill out the Allergy Action Plan
2. Parent must supply the PALS Program the required medication.</td>
<td>❑ Wears contacts/glasses
❑ Fainting
❑ Ear problems/tubes
❑ Hearing impairment
❑ Emotional behaviors
❑ ADD/ADHD
❑ Medicated
❑ Non-medicated
❑ Nosebleeds

Will your child be taking medication while at PALS?

❑ Yes ❑ No

If yes, parent/guardian must complete the Medication Dispending Information Form and Permission to Dispense Medication Waiver.</td>
</tr>
</table>

Are there any special family circumstances we should aware of (divorce, death, recent move, etc.)?

What is your child's primary language spoken at home? Are there additional languages spoken?

Is there any information that might be helpful to us in making your child's time at PALS most beneficial to them?

I give my permission for my child to receive necessary health care and emergency medical treatment. This data form is complete and accurate. I will not allow my child to attend if they become exposed to any contagious disease, or if for any reason, I do not consider my child to be in good physical condition.

Parent/Guardian signature:_____Date:_____