



**Summer Program – Illustration Matters – Circle one (1)**

July 6-10 (Grades, 6-8)

August 3-7 (High School)

**GENERAL INFORMATION**

Below you will see a few reminders and attached are the forms that are necessary for you to fill out and return. Keep a photo copy for your records.

**PICKUP AND DROP OFF**

**DROP-OFF begins at 12:30 pm** and will occur in front of Breck Fitness Center (Program Headquarters), located to the left of Blake Dining Commons. If you must park, please use the circle drive and walk your daughter over. Follow the signs for the entrance point and a staff member will be there to greet you and take care of the sign-in process.

**PICK-UP begins at 4:30 pm** and will occur in the same fashion, use the same entrance and exit points.

Participants who ride a bike or walk to the program will need to have a written authorization form in addition to the pick-up form. (All bikers must provide a lock for their bikes.)

- **FOR DROP-OFF AND PICK-UP TO FUNCTION EFFICIENTLY AND TO AVOID PROBLEMS, ALL PARENTS ARE ASKED TO MAKE ARRANGEMENTS AS SOON AS POSSIBLE. NO ATTENDEE WILL BE ALLOWED TO LEAVE UNTIL ALL NOTIFICATIONS HAVE BEEN CONFIRMED.**

**CHECK-IN and CHECK-OUT:**

**All participant s** will need to check-in each day with the program staff. Any notes concerning drop-off and pick-up should be given directly to the program director. Arrangements need to be in writing. Check-out will again require the program attendees to notify the program director when leaving for the day. Authorized parents or guardians will be required to sign in and out each day during check-in and check-out. See the attached form.

**OFFICE LOCATION:**

The office will have its headquarters in the lobby of Breck Fitness Center. The direct telephone number is 565-1307. For other emergencies, please call 565-1000 and ask for the special programs director, Briana Sitler.

**LUNCH & SNACK TIME:**

Illustration Matters will not provide lunch or snacks. All attendees are encouraged to bring their own.

**BREAKS & WATER STATIONS:**

Water breaks will occur throughout the program.

**EQUIPMENT NEEDS FOR ATTENDEES:**

None, just a willingness to learn!

**IMPORTANT INFORMATION:**

Enclosed you will find a series of forms which need to be filled out and returned by July 20, two weeks prior the 1<sup>st</sup> day of the session begins. These forms will be kept on file in the **Illustration Matters!** Office for the duration of the program.

If you have any questions please feel free to call me (Briana Sitler) at 413 565-1066.

**DRESS CODE**

The dress code for students is casual (sneakers or close-toed shoes preferred. No tank/halter tops, or bare midriffs, we will be primarily in an air-conditioned room, it can be cold!!).

**IMPORTANT INFORMATION**

Enclosed you will find a series of forms that need to be filled out in their entirety and received in our office PRIOR to the first day of the program. The earlier the better! These forms will be kept on file for reference and safety for the duration of the program. If you have any questions, please feel free to call (413) 565-1066. The completed forms may be faxed to the attention of Briana Sitler at (413) 565-1118, or mailed to Bay Path College, Attn: Briana Sitler, 588 Longmeadow Street, Longmeadow, MA 01106. Please keep a copy of all forms for your personal records.

**CHECKLIST OF FORMS**

- Health/Medical Information Sheet \_\_\_\_\_
- Medication Sheet \_\_\_\_\_
- Self Medication Sheet \_\_\_\_\_
- Transportation Form \_\_\_\_\_
- Liability Form \_\_\_\_\_



**Transportation record - Illustration Matters – Circle one (1)**

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Daily transportation of students to and from **Illustration Matters!** @ Bay Path College will be the sole responsibility of a parent or authorized guardian. Information on this person will include the name/s of the authorized drop off and pick-up, the staff will ask for a copy of this person/s driver's license. Changes in the authorized parent or guardian must be in writing to the Program Director.

Please notify us if your daughter will be driving to this program.

All Drop-offs and pick-ups will be required to sign the daily log as proof of participant arriving and leaving Illustration Matters! If you have any questions please call the director of special programs at 565-1066.

If you choose to allow your daughter to walk or ride a bike to the campus, then a separate section must be filled out on this form. Bikers and walkers will be released before vehicle pickup. These participants will also be escorted across Longmeadow Street by a staff member by parents request, see below.

NAME of Attendee: \_\_\_\_\_

**Daily Vehicle Drop-Off and Pick-up Program**

Authorized Individual/s to drop-off and pick-up:

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Comments: \_\_\_\_\_

**Daily Biker or Walker Program**

Biker \_\_\_\_\_ Walker \_\_\_\_\_

Does participant need assistance crossing Longmeadow Street? Yes \_\_\_ No \_\_\_

I have read, understand, and accept the conditions outlined in the transportation record.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**Daily Driver**

Name: \_\_\_\_\_

Comments: \_\_\_\_\_



**Release of Liability record– Illustration Matters – Circle one (1)**

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**DISCLOSURE**

The Bay Path College *Illustration Matters!* program is mostly within a classroom or computer lab setting but also consists of time walking to and from various campus buildings.

**RELEASE OF LIABILITY**

I understand that part of the Bay Path College *Illustration Matters!* program may involve some physical activity. I affirm that my (daughter's) health is good and that I am (she is) not under a physician's care for any undisclosed condition that bears upon my (her) fitness to participate in the above referenced activities. I understand that each participant must assume the risk of physical injury that could result from any of these activities. I release Bay Path College, its staff members, and Board of Trustees from all liability for any injury to me (my daughter) from participation in these activities.

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Parent/Guardian's Signature

Date



**Medical History Health Form– Illustration Matters – Circle one (1)**

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NAME of PARTICIPANT: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/TOWN: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

NAME of PARENTS: \_\_\_\_\_

HOME PHONE #: \_\_\_\_\_ WORK PHONE#: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

IN CASE of EMERGENCY, NOTIFY: \_\_\_\_\_

RELATIONSHIP to STUDENT: \_\_\_\_\_ DAY PHONE#: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ DATE OF LAST EXAM: \_\_\_\_\_

**IMMUNIZATION RECORD: (MONTH, DAY, YEAR FOR EACH DOSE)**

<b>Immunization</b>	<b>Date</b>					<b>Immunization</b>	<b>Date</b>
	1 <sup>st</sup> Dose	2 <sup>nd</sup> Dose	3 <sup>rd</sup> Dose	4 <sup>th</sup> Dose	5 <sup>th</sup> Dose		
DTP/DTaP/DT/TD						MMR (1 <sup>st</sup> Dose)	
OPV/IPV						Measles (2 <sup>nd</sup> Dose)	
HIB (Haemophilus Influenza Type B)						Varicella (Chicken Pox)	
Hepatitis B						Other	

A signed copy of your child's immunization record attached is acceptable.

Identify any known medical illness or disorder (emotional or physical) that would currently pose a risk to other students or which would affect the student's functional ability to participate safely. Please also indicate if there are additional medical concerns of which the program staff should be aware (i.e. seizures, diabetes, etc.) \_\_\_\_\_

Does the student have any physical disabilities (temporary or permanent)?

Yes  No

Explain: \_\_\_\_\_

Is this student taking prescription medication on a daily basis for a chronic illness or condition?

Yes  No

If yes, indicate medication: \_\_\_\_\_

*IMPORTANT NOTE: Bay Path College will not be responsible for dispensing medication, unless all forms are attached and permission given. See self-medication waiver for prescriptions such as epipens and inhalers.*

Does the student have allergies?  Yes  No

If yes, what specific type/s of allergies and the normal reaction: \_\_\_\_\_

\_\_\_\_\_  
(If allergic to bee stings, the student must bring an epipen.)

**SPECIFIC DIETARY RESTRICTIONS:** \_\_\_\_\_

### **PARENT/GUARDIAN AUTHORIZATION (Required for all Participants)**

This health history is correct and complete to the best of my knowledge, and the student named above has permission to participate in all program activities except as noted by an examining authority or me. I also confirm that my child has received and is up to date on all necessary immunizations required by law for participation. If I cannot be reached in an emergency, I hereby authorize permission to the **summer programs@baypath** staff to transport my child to the nearest hospital, to secure proper medical treatment for, and order injection, anesthesia for surgery for the child named above.

**PHYSICIAN'S NAME:** \_\_\_\_\_

**PHYSICIAN'S TELEPHONE NUMBER** \_\_\_\_\_

**FULL INSURANCE INFORMATION** is required for coordination of benefits. (Attach a copy of your insurance ID card.) Every student is required to have health insurance.

Name of insurance company: \_\_\_\_\_

Address of insurance company: \_\_\_\_\_

Policy or identification number: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Prescription coverage: Yes \_\_\_ No \_\_\_

Parent's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### **For Office Use Only:**

Reviewed by \_\_\_\_\_ Copy sent to Medical Director \_\_\_\_\_



**Self Medication Waiver– Illustration Matters – Circle one (1)**

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Complete this form only if self-medication is required.

Students Name: \_\_\_\_\_

Summer Program/Dates: \_\_\_\_\_

Parent/Guardian Authorization

My child has a physical condition that requires her to routinely receive medication as quickly as possible in order to avoid a medical crisis or for better disease control. In the interest of her personal well being, I hereby grant my child the authority to carry the medication or medications listed below and to self-administer it as directed by the prescribing physician when needed.

Medication	Dosage	Administration and Dosing Schedule	Condition requiring self-medication	Comments

She has been instructed in all self-administered medication(s) proper use.

In granting this permission for my child to self-medicate, I hereby release Bay Path College and its Trustees, officers, employees and students from all claims and damages which may arise from any impairment of my child's health or for any condition that may arise from the administration or lack of administration of such medications.

Parent/Guardian Signatures: \_\_\_\_\_ Date: \_\_\_\_\_

Note: A completed and signed copy of this form must be received by the program director no later than the first day of the summer program.

Please note: All prescription and over the counter medications to be taken by a program participant (under 18 year of age) must be kept in the Bay Path college Program Headquarters where a schedule will be set up for dispensing of medications. All Medications must be in the pharmacy bottle or original store container with proper labeling.

It is advised prior to mailing that you make a copy of all forms to hand carry. No child will be allowed to stay without health forms.



**Self -Medication Sheet– Illustration Matters – Circle one (1)**

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This form must be completed and signed by Parent/Guardian & Health Care Provider

ORDERS FOR: Name \_\_\_\_\_ DOB: \_\_\_\_\_ Weight \_\_\_\_\_

**Standard Over the Counter Medications** (The following medications are available at the Student Health Center and will be administered at the discretion of an RN or LPN if approval is indicated by the programs's Healthcare provider.): Any other over the counter medications the child routinely takes and will be bringing with them must be added to this list. **No over-the-counter medications can be dispensed without completion of this form.**

DRUG NAME	HOW ADMINISTERED (INDICATE PREFERRED METHOD)	DOSAGE	SCHEDULE AND INDICATIONS	ORDERED BY HEALTHCARE PROVIDER	COMMENTS
Ibuprofen				Yes No	
Acetaminophen				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	

**\*If any medications are to be self administered (such as inhalers or an epipen) the parent must fill out self-medication waiver form\***

**Prescription Medications** (Must complete with patient's current regimen for both scheduled and PRN medications use 2nd page if needed)

DRUG NAME	HOW ADMINISTERED (INDICATE PREFERRED METHOD)	DOSAGE	SCHEDULE AND INDICATIONS	COMMENTS

**\*\*No routine medications should be listed under prescription medications.**

**Both signatures requested:**

Parent signature \_\_\_\_\_ Date \_\_\_\_\_

Parent signature \_\_\_\_\_ Date \_\_\_\_\_

Health Care Provider ( Name: \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_ License# \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_