West Fargo Park District
Application for Special Needs Program

Complete one form per individual and email it to info@wfparks.org or return it to:

West Fargo Park District
Attention: Logan Kritzeck
601 26th Ave E
West Fargo, ND 58078

Check the program you are applying for: ____Camp-A-Day (Grades 1-8)

Participant's Name: _____
Address: _____

City: _____ State: _____ Zip: _____

Parent's Phone Numbers: (h) _____(c) _____ (w) _____

Primary Email Address: _____

Emergency Contact & Phone Number: _____

Parent/Guardian Name(s): _____

School Attending: _____ Teacher: _____ ESY Location: (if applicable) _____

Does the applicant have Seizures? _____

Explain: _____

_____

_____

Is the applicant currently taking medication? Yes No

If yes, please list medication(s): _____

_____

_____

_____

(TURN OVER)

Does the applicant have allergies? Yes No

If yes, please give a brief explanation: _____
_____

_____

Does the applicant: Use a wheelchair---------- Yes No
Use crutches---------- Yes No
Use/wear braces---------- Yes No
Need assistance climbing stairs--------- Yes No
Need assistance dressing---------- Yes No
Need assistance eating---------- Yes No
Need assistance using the bathroom--- Yes No
Have difficulty controlling bladder---- Yes No
Have speech difficulty---------- Yes No
Have hearing difficulty---------- Yes No

Please give a brief explanation of each "Yes" circled above:_____
_____
_____
_____
_____

Will the school district be paying for the child to participate? (This must be included in their IEP/ESY services) Yes No

Does your child need any assistance to be in this program? Yes No

If yes please list the assistance need from either the school district or the West Fargo Park District:

_____
_____
_____
_____

Please list any other information you would like us to know about the applicant:

_____

_____

_____

_____

I hereby give my approval for (applicant's name) _____ to participate in the West Fargo Park District Special Needs Program. I understand that the West Fargo Park District does not provide medical insurance nor will the West Fargo Park District be responsible for medical expenses. I hereby authorize the instructors of this program to act for me according to their best judgment in any emergency requiring medical attention and hereby waive and release the West Fargo Park District and its instructors from any and all liability for any injuries. I also certify that my child is medically fit to participate in this program and has sufficient medical insurance. I give permission for the applicant to participate in field trips and ride on a bus. If in Camp-A-Day program, I give permission for the applicant to swim at the Veterans Memorial Pool and the Hulbert Aquatics Center. I also understand that the West Fargo Park District staff will not administer medication to participants.

_____

Printed Name of Parent or Guardian

_____ _____

Signature ***Date***