Ready, Set, Camp! 2022

$950

___Ward or ___Jefferson (please check one)

All lines must be filled in on this registration form

Name: ____ Age: ______ Date of Birth: ____________

Gender: (M / F) Camper Shirt Size(youth sizes): (S / M / L / XL)

What school does your child attend regularly? ____

Grade completed as of 6/24/22: ______ Teacher's Name: ____

Address: ____ Zip Code: ___________

____

Home Phone #: _____________________________________Cell Phone #: __________________________________

E-mail address: ____

Emergency Contact Person: ____Relationship to Camper: ___________

Emergency Contact's (cell) Phone: ____

Do you feel that your child is physically/emotionally fit to participate in our program without endangering his/her health and the well-being of other children? ____YES ___NO

Special Attention Required? If yes, please specify: ____

____

Pediatrician: _______________________________________ Phone #: ____________________ Last Visit: ______

Does your child wander? ____ Speak and understand? ___ Shy? ___ Speak and understand more than 1 language? _________

If yes, what language: _______________________ Primary language spoken at home: ______________________

Does your child take medication? If yes, the type: ____

For: ______________________________________ Dosage: ______________________ Time(s) given: _________

(You must request and sign a Medical Release Form for medication to be administered during camp hours – including inhalers and OTC medication.)

Is child asthmatic? ___ If yes, does he/she carry an inhaler? __________

Any issues in the area of:

- Bathroom? ____
- Dress/undress (swim/water play)? __________________________
- Eating? ____
- Physical handicaps? ______________________________________
- Fears? ____
- Heart Problems? ____
- Allergies? ____

*****Is there any other information about your child you would like the Camp Staff to take into consideration? This extra information helps the camp staff better understand the camper. *****

____

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____

Camp Waiver Form

I hereby give my consent for my child to participate in trips, swimming and regular programming planned for the Summer Day Camp July 5, 2022 – August 12, 2022 during camp hours (8:30a-3:30p). The children will either walk or be transported by bus under the care and supervision of Camp Staff members. While every precaution will be taken to safeguard my child, it is understood that I release New Rochelle Parks and Recreation, City of New Rochelle, and its sponsoring agents from all responsibility, in case of accident or illness, including COVID-19 related illness while participating in this program.

I hereby give New Rochelle Parks and Recreation permission to use any photographs/videos taken pertaining to the Summer Day Camp.

I hereby give the City School District of New Rochelle permission to release any information concerning my child to the New Rochelle Parks and Recreation's Summer Day Camp administration/staff.

Name of Child: ____

X Signature of Parent or Guardian: ____

(REQUIRED FOR ALL APPLICANTS – APPLICATION WILL NOT BE ACCEPTED WITHOUT SIGNATURE)

Date: ______/______ /2022

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EARLY DROP-OFF REGISTRATION

Only sign if submitting the additional fee for Early Drop-Off.

X Signature:

Parent/Guardian Signature required here for Early Drop-Off ($165) starting at 8:15 am - Campers will only be on this roster after registering with the Parks & Recreation Office.

MEDICAL HISTORY AND EMERGENCY FORM

THIS FORM MUST BE FILLED OUT BY PARENT OR GUARDIAN. THE INFORMATION IS REQUIRED BY N.Y. STATE LAW. YOUR CHILD WILL NOT BE ADMITTED INTO CAMP WITHOUT THIS FORM COMPLETELY FILLED OUT. IMMUNIZATION RECORDS ARE TO BE ATTACHED

NAME: ______________________________________DATE OF BIRTH: ___________GENDER: M/F

ADDRESS: ____________________________________ZIP: __________PHONE: _________________

PARENT/GUARDIAN NAME: ____________________________________WORK PHONE: ___________

IF NOT AVAILABLE IN EMERGENCY, NOTIFY: ____

EMERGENCY CONTACT'S RELATIONSHIP TO CAMPER: _________________________PHONE: ________

PEDIATRICIAN: ____ PHONE: ________

DATE OF LAST VISIT: ______________IS CHILD ON MEDICATION? ________ TYPE: ________________

TIME GIVEN: ____________

IS CHILD EPILEPTIC? ___________DATE OF LAST SEIZURE: ____________________DIABETIC? ________

HEALTH HISTORY

IS YOUR CHILD'S HEALTH GENERALLY GOOD? ___________________

ALLERGIES/SENSITIVITY

HAS CHILD HAD, OR SUBJECT TO:

RHEUMATIC FEVER ___
SINUS TROUBLE ___
EAR INFECTIONS ___
CONVULSIONS ___
DIABETES ___
FOODS ---

CHICKEN POX ---
OTHER ---

FAINTING SPELLS ___
POISON IVY ___
INSECT STINGS ___
PENICILLIN ___
OTHER DRUGS ___
HAY FEVER ___
ASTHMA ___

OPERATIONS OR SERIOUR INJURIES: ____
____DATE: _______________________

RESTRICTIONS PLACED ON PROGRAM ACTIVITIES: ____
____

MODIFICATIONS/RESTRICTIONS/SUPPORTS IN PLACE DURING THE SCHOOL YEAR: ____________________________________
____
____

IMMUNIZATION RECORD:

A COPY OF CAMPER'S IMMUNIZATION RECORD MUST BE ATTACHED TO THIS FORM.

DIPTHERIA/TETANUS TOXOID (4 DOSES)	DATE:	___	___	___	___
ORAL POLIO VACCINE (3 OR MORE DOSES)	DATE:	___	___	___	
LIVE MEASLES VACCINE (1 DOSE)	DATE:	___			
LIVE RUBELLA VACCINE (1 DOSE)	DATE:	___			
LIVE MUMPS VACCINE (1 DOSE)	DATE:	___			
VARICELLA (CHICKEN POX)	DATE:	___			
HAEMOPHILUS INFLUENZA TYPE B	DATE:	___			
HEPATITUS B	DATE:	___			

PARENT'S AUTHORIZATION

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me or by his/her doctor. If emergency care is needed by my son/daughter (print name: ____)
while he/she is attending or being transported to or from Camp, I hereby give my permission to the authorized agents of New Rochelle Parks and Recreation to obtain a doctor to medically treat my son/daughter. I authorize transportation to, and treatment at, a hospital where required. I agree to assume all responsibility for all charges so incurred. I also agree to allow New Rochelle Parks and Recreation to release information to the hospital or to the doctor as may be required.

INSURANCE TYPE/NUMBER: ____

MEDICAID NUMBER: ____

SIGNATURE OF PARENT/GUARDIAN:

X____

DATE: ____

CAMP HEALTH OFFICE USE ONLY

NOTES:

REVIEWED BY: ____DATE: _____