

Summer Day Camp Program 2019

___ (\$650/\$700) Full Day Camp @ Ward **OR** ___ (\$600/\$650) Day Camp @ Jefferson

All lines must be filled in on this registration form

Name: _____ Age: _____ Date of Birth: _____

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

What school does your child attend regularly? _____

Grade completed as of 6/24/19: _____ 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 wellbeing 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 that you would like the Camp Staff to take into consideration? This extra information will help the camp staff in understanding the camper.*****

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 1, 2019 – August 9, 2019 during camp hours (9:30a-3:30p). The children will either walk or be conveyed by bus under the care and supervision of Camp Staff members. While every precaution will be taken to safeguard the children at Camp, it is understood that you release the Department of Parks and Recreation, City of New Rochelle, New York and its agents sponsoring this program from all responsibility in case of accident while your child is being transported to and from, or while participating in and/or at these activities.

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: ____/____/2019

EARLY DROP-OFF REGISTRATION (Ward site only)

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

X Signature: _____

Parent/Guardian Signature required here for Early Drop-Off (\$165.00) starting at 8:15 am(Ward only) - 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 RECORD ARE TO BE ATTACH

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, IN GENERAL, GOOD? _____

ALLERGIES/SENSITIVITY

HAS CHILD HAD, OR IS CHILD SUBJECT TO:

RHEUMATIC FEVER _____

SINUS TROUBLE _____

EAR INFECTIONS _____

CONVULSIONS _____

DIABETES _____

FOODS _____

CHICKEN POX ---

OTHER _____

FAINING 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.

DIPHTHERIA/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: _____