White Plains YMCA 2016 Summer Camp Registration Form

Camper Information

Child's First Name: _____ Child's Last Name: _____

Date of Birth: _____ Gender: _____ Age: _____ Shirt size: □S □ M □ L □ XL

What grade will your child be entering in the Fall of 2016?: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Allergies: _____

_____

_____

Parents/guardians information

1. Parent's Name _____ Cell Number _____
   Email address_____

1. Parent's Name _____ Cell Number _____
   Email address_____

Emergency contact and pick up Information

Please fill out the information below to explain who is allowed to pick up your child from camp this summer. Parents are already assumed as allowed to pick up their children, unless previously noted with proper documentation with the camp director. Note: anyone who is not listed below will not be allowed to leave the White Plains YMCA property with your child for any reason unless verified in person from a parent/guardian prior to the time of the actual pick-up.

Name _____ Phone: _____

Name _____ Phone: _____

Name _____ Phone: _____

Important Information Form

Hospital and Insurance Information

Name of emergency contact person: _____ Phone #: _____

Doctor's name: _____ Phone #: _____

Hospitalization insurance co._____

Identification number_____

Note: If child is required to take medication during camp hours, a separate medical authorization form must be completed by the parent and physician. The child will be taken to White Plains Hospital if any of the parents or emergency contacts cannot be reached

Parent/Guardian's Signature: _____ Date: _____

Release of Liability

- ☐ **Transportation:** I give permission for the White Plains YMCA staff to transport my child when necessary.
- ☐ **Release Statement:** I hereby release the executive director and all employees of White Plains YMCA from all claims of liability for any damages or injuries that may be sustained while my child is in camp.
- ☐ **Photo Release:** I hereby give permission for my child's photograph to be used in White Plains YMCA publications, social media and for advertising and promotions.
- ☐ **Release of Minors:** all campers are released at the end of the program to the parent/guardians. No child will be released to another person without a written release form from the parent guardian. Please sign to confirm your understanding.
- ☐ **Refund Policy** I have read/understood the White Plains YMCA policy
- ☐ **No camper will be able to continue to attend camp until all payments are completed**
- ☐ **Enrollment Policy:** I shall not be entitled to any reduction, refund or allowance in the event of my child's withdrawal or absence from the program for any reason.

Signature _____ Date: _____

Billing Form

Tuition Information

(Please check off the weeks for child's participations)

*$100.00 Deposit to secure child's spot

*$55.00 Program Membership

*$35.00 Late Fee will be included after due date

Week 1-5 are due June 20th 2016 **Week 6-8 are due July 20th 2016**

Camp from 8:00 – 4:00 ($385)

☐ Week 1 6/27—7/1 ☐ Week 2 7/5—7/8 ☐ Week 3 7/11—7/15 ☐ Week 4 7/18—7/22

☐ Week 5 7/25—7/29 ☐ Week 6 8/1—8/5 ☐ Week 7 8/8—8/12 ☐ Week 8 8/15—8/19

Camp from 8:00 – 6:30 ($470)

☐ Week 1 6/27—7/1 ☐ Week 2 7/5—7/8 ☐ Week 3 7/11—7/15 ☐ Week 4 7/18—7/22

☐ Week 5 7/25—7/29 ☐ Week 6 8/1—8/5 ☐ Week 7 8/8—8/12 ☐ Week 8 8/15—8/19

Credit Card Information

Card Type: ____ Visa _____ MasterCard _____Amex _____Discover

Card #: ___ ___ ___ ___- ___ ___ ___ ___ -___ ___ ___ ___- ___ ___ ___ ___

Expiration Date: Month & Year __ __/__ __ __ __

_____ Date _____

Signature of bank depositor or card holder (as shown on bank or credit /debit card records).

The YMCA of Central & Northern Westchester is committed to protecting the privacy of members, program participants and guests. All information provided to the YMCA with regard to any individual, family or group is for internal use only.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:

Immunizations required for entry into day care ☐ Yes ☐ No

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date	2nd Date	3rd Date	4th Date	5th Date
Polio (IPV or OPV)	1st Date	2nd Date	3rd Date	4th Date	
Haemophilus influenzae type B (Hib)	1st Date	2nd Date	3rd Date	4th Date **OR** 1st Date (if given on or after 15 months of age)	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date	2nd Date	3rd Date	4th Date	
Hepatitis B	1st Date	2nd Date	3rd Date		
Measles, Mumps and Rubella (MMR)	1st Date	2nd Date			
Varicella (also known as Chicken Pox)	1st Date	2nd Date			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Tests

Tuberculin Test Date: __/__/____ Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: __/__/____

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year __/__/____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years __/__/____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

__/__/____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) Phone

Date

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.