



FOR YOUTH DEVELOPMENT™  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

# FLUSHING Y SUMMER CAMP REGISTRATION FORM

\*\*\*\*\*

Camper's Name \_\_\_\_\_ Age \_\_\_\_\_  
 (First) (Middle) (Last)

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_ T-Shirt Size: \_\_\_\_\_

Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_, NY or \_\_\_\_\_, Zip. \_\_\_\_\_

Guardian #1 Name: \_\_\_\_\_ Guardian #2 Name: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_

Business #: (\_\_\_\_) \_\_\_\_\_ Business #: (\_\_\_\_) \_\_\_\_\_

Mobile Phone/Pager: (\_\_\_\_) \_\_\_\_\_ Mobile Phone/Pager: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_@\_\_\_\_\_ Email Address: \_\_\_\_\_@\_\_\_\_\_

## Authorized Pick Up and Emergency Contact Information

At dismissal and/or incase of emergency the following people are authorized to pick up my child:

Guardian #1:  YES  NO      Guardian #2:  YES  NO

At least two additional authorized pickups 18 years old and older are required:

1. _____	Relation: _____	Phone # _____
2. _____	Relation: _____	Phone # _____
3. _____	Relation: _____	Phone # _____
4. _____	Relation: _____	Phone # _____

## Dismissal Options

\_\_\_\_\_(Initial) An authorized pickup (18 years old & older) will pick my child up from the YMCA at approx. \_\_\_\_\_ PM.

My child will be using the extended care program for:  AM  PM  BOTH \_\_\_\_\_(Initial)

My child will be using the \_\_\_\_\_ (enter bus comp.) for:  AM  PM  BOTH \_\_\_\_\_(Initial)

### Options only for children over 10 years old:

\_\_\_\_\_(Initial) I give permission for my child to sign-out from the program at (4:30-6:00 pm) \_\_\_\_\_ PM.

\_\_\_\_\_(Initial) I give permission for my child to sign-out from the program in the presence of any authorized pickup.

\*\*\*\*\* **Office Use Only** \*\*\*\*\*

AS400#: _____ - _____ T-Shirt: _____ Medical: _____ Third Party: 1 199/ACS/Other _____
--

## Camps and Sessions:

### Flushing Kindercamp (2-5)

<u>5 days a week:</u>	<u>3 days a week:</u> M T W Th F <small>(Circle Days)</small>
<input type="checkbox"/> Session 1: \$340	<input type="checkbox"/> Session 1: \$295
<input type="checkbox"/> Session 2: \$375	<input type="checkbox"/> Session 2: \$295
<input type="checkbox"/> Session 3: \$375	<input type="checkbox"/> Session 3: \$295
<input type="checkbox"/> Session 4: \$375	<input type="checkbox"/> Session 4: \$295

### Kindercamp Extended ONLY

AM (7:00-9:00)	PM (4:00-6:00)	BOTH
<input type="checkbox"/> Session 1: \$45	<input type="checkbox"/> Session 1: \$45	<input type="checkbox"/> Session 1: \$81
<input type="checkbox"/> Session 2: \$50	<input type="checkbox"/> Session 2: \$50	<input type="checkbox"/> Session 2: \$90
<input type="checkbox"/> Session 3: \$50	<input type="checkbox"/> Session 3: \$50	<input type="checkbox"/> Session 3: \$90
<input type="checkbox"/> Session 4: \$50	<input type="checkbox"/> Session 4: \$50	<input type="checkbox"/> Session 4: \$90

**Session 1: 7/1-7/12, Session 2: 7/15-7/26, Session 3: 7/29-8/9 and Session 4: 8/12-8/23.**

- Session 1 is 9 days (July 4<sup>th</sup> No Camp)

### Day Camp (5.5 – 15 yrs old)

Day Camp: (5.5-11)	Swim Camp (8-12)
<input type="checkbox"/> Session 1 \$423	<input type="checkbox"/> Session 1 \$513
<input type="checkbox"/> Session 2 \$470	<input type="checkbox"/> Session 2 \$570
<input type="checkbox"/> Session 3 \$470	<input type="checkbox"/> Session 3 \$570
<input type="checkbox"/> Session 4 \$470	<input type="checkbox"/> Session 4 \$570

#### Teen Camp: (12-15)

<input type="checkbox"/> Session 1 \$423
<input type="checkbox"/> Session 2 \$470
<input type="checkbox"/> Session 3 \$470
<input type="checkbox"/> Session 4 \$470

### Day Camp Extended ONLY

AM (7:00-8:30)	PM (4:30-6:00)	Both
<input type="checkbox"/> Session 1: \$40.50	<input type="checkbox"/> Session 1: \$40.50	<input type="checkbox"/> Session 1: \$72
<input type="checkbox"/> Session 2: \$45	<input type="checkbox"/> Session 2: \$45	<input type="checkbox"/> Session 2: \$80
<input type="checkbox"/> Session 3: \$45	<input type="checkbox"/> Session 3: \$45	<input type="checkbox"/> Session 3: \$80
<input type="checkbox"/> Session 4: \$45	<input type="checkbox"/> Session 4: \$45	<input type="checkbox"/> Session 4: \$80

**Camp Total:** \$ \_\_\_\_\_

**Extended Total:** \$ \_\_\_\_\_

**Total Fees:** \$ \_\_\_\_\_

**- Discounts:** \$ \_\_\_\_\_

**Grand Total:** \$ \_\_\_\_\_

## Direct Payment Plan Authorization

I authorize the YMCA to charge my credit card account on Saturday June 8<sup>th</sup> for Session 1 & 2 in the amount of \$ \_\_\_\_\_ and on Monday July 8<sup>th</sup> for Session 3 & 4 in the amount of \$ \_\_\_\_\_ in fulfillment of my child's summer day camp payment obligation.

AMEX     Visa     Master Card     Discover    Card Holder's Signature \_\_\_\_\_

Credit Card # \_\_\_\_\_ Expiration Date \_\_\_\_/\_\_\_\_ Security Verification \_\_\_\_\_

## Standard Release Form

I, the undersigned give permission for my child to participate in all summer camp activities for the days he/she attends. I understand that no refund or credit will be given for missed days under any circumstances. I understand that I must have a completed medical form on file **BEFORE** the first day of the summer camp program. I also hereby give authority to the YMCA staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible. Also, in consideration of the goodwill, public service, and community aid provided by the YMCA of Greater New York, which I support and from which I have received benefit, I hereby grant permission to the YMCA to use my child's name, to take and publish photographs, videotapes or motion pictures of him/her which include his/her voice, in any media for any legitimate purpose. I release all rights to such photographs, videotapes, motion pictures and recordings. I acknowledge that the YMCA will be the sole owner of all rights arising out of their use for all purposes. I understand that I shall receive no compensation from their use from any source whatsoever.

Parent or Guardian's Print Name \_\_\_\_\_

Parent or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

\*If at any point the information on the registration form needs to be changed, you must submit all changes in writing.

**HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS**

**(This side to be filled in by Parent before presentation to Physician)**

**NAME OF PROGRAM:** Flushing YMCA Day Camp

Permit No. 85: \_\_\_\_\_

_____	_____	____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child's Last Name	First Name	Date of Birth	Sex

Home Address: \_\_\_\_\_ Tel. No. \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Tel. No. \_\_\_\_\_

Place of Employment:

Father Guardian: \_\_\_\_\_ Tel. No. \_\_\_\_\_

Mother Guardian: \_\_\_\_\_ Tel. No. \_\_\_\_\_

In Case of Emergency, please notify: \_\_\_\_\_ Tel. No. \_\_\_\_\_

If Parent/Guardian are not available in an emergency, please notify:

1. \_\_\_\_\_ Tel. No. \_\_\_\_\_

2. \_\_\_\_\_ Tel. No. \_\_\_\_\_

**Important:** Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance.

Yes  No If yes, state type of exposure: \_\_\_\_\_

**HEALTH HISTORY:** (Check and give approximate dates)

	Allergies	Diseases
Ear Infections _____	Hay Fever _____	Check Pox _____
Rheumatic Fever _____	Ivy Poisoning, etc. _____	Measles _____
Convulsion _____	Insect Stings _____	German Measles _____
Diabetes _____	Penicillin _____	Mumps _____
Behavior _____	Other Drugs _____	Other Contagious Illnesses _____
Asthmas _____	_____	_____

Other Past Illnesses: \_\_\_\_\_

Operations or Serious Injuries (Dates): \_\_\_\_\_

Hospitalization (Dates): \_\_\_\_\_

Chronic or Recurring Illness: \_\_\_\_\_

Any specific activities to be encouraged? \_\_\_\_\_

Conditions that require activity to be restricted? \_\_\_\_\_

Permission for all program activities unless otherwise noted by doctor: \_\_\_\_\_

Appliance worn (glasses, contacts, etc.): \_\_\_\_\_

Medication taken: \_\_\_\_\_

Suggestion from Parent/Guardian: \_\_\_\_\_

**CONSENT FOR EMERGENCY MEDICAL TREATMENT**

*I do hereby give authority to the Day Camp and Year Round Afterschool and Youth Center Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.*

_____	_____	_____	_____
Relationship	Signature	Date	Telephone No.

**PHYSICAL EXAMINATION**

(To be filled out by Physician. Please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information, which will help to serve the needs of this child in Day Camps and Afterschool and Youth Center programs.

<b>IMMUNIZATION HISTORY:</b> This is a record of dates of basic immunization and most recent booster doses.					
Type	Date	Date	Date	Date	Date
DtaP, DTP or TD					
OPV/IPV					
MMR					
Hemophilus Influenza Type					
Hepatitis B					
Varicella					
Other (Specify):					

**MEDICAL EXAMINATION:** To be filled out by license physician  
 Examination is acceptable when performed no more than 12 months prior to arrival at camp.  
 Code: S = Satisfactory  
 X = Not Satisfactory, Explain:  
 O = Not examined

General Appearance: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Hgb Test (Date): \_\_\_\_\_  
 Urinalysis: Date: \_\_\_\_\_ Posture & Spine: \_\_\_\_\_ Throat & Tonsils: \_\_\_\_\_  
 Eyes \_\_\_\_\_ Vision \_\_\_\_\_ W/ Glasses \_\_\_\_\_ Extremities \_\_\_\_\_ Heart \_\_\_\_\_  
 Ears \_\_\_\_\_ Hearing \_\_\_\_\_ Feet: \_\_\_\_\_ Lungs \_\_\_\_\_ Skin \_\_\_\_\_  
 Nose \_\_\_\_\_ Teeth \_\_\_\_\_ Abdomen \_\_\_\_\_ Hernia \_\_\_\_\_  
 Genitalia \_\_\_\_\_  
 Neurological Findings \_\_\_\_\_  
 Describe Abnormal Findings and/or Handicapped Conditions \_\_\_\_\_

Has child ever received products containing horse serum? \_\_\_\_\_  
 Allergy: (Please specify) \_\_\_\_\_

Recommendations and restrictions while in After-school:  
 Special Diet: \_\_\_\_\_  
 Special Medicine (Name it) \_\_\_\_\_  
 Is parent/guardian sending special medicine? \_\_\_\_\_  
 Swimming \_\_\_\_\_ Diving \_\_\_\_\_  
 Activity Restrictions \_\_\_\_\_

General Appraisal: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Day Camp/Year Round Afterschool and Youth Center activities, except as noted above.	
_____ MD	_____
Physician's Name (PLEASE PRINT)	Examining Physician's Signature
Telephone: _____	Address: _____
Date of Examination: _____	_____