



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

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

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:

____ 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.
(Initial)

*****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 (Circle Days)
<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 4th 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 8th for Session 1 & 2 in the amount of \$ _____ and on Monday July 8th 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: _____

_____/_____/_____
Child's Last Name First Name Date of Birth ☐ Male ☐ Female
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.

IMMUNIZATION HISTORY: 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: _____