



YWCA CAMP FUNKIST SUMMER 2018

515 North Street White Plains, NY | (914) 949-6227 x168 | www.ywcaawpcw.org | frontdesk@ywcaawpcw.org

REGISTRATION CHECKLIST

(One form per child. All pages of application MUST be filled out, where applicable.)

Child's Name: _____

Group: _____

<input type="checkbox"/> Contact Form (Including T-Shirt size, all Emergency contacts, and the permission & Indemnity sign off)
<input type="checkbox"/> Terms of Registration
<input type="checkbox"/> Contract and Fee Schedule
<input type="checkbox"/> Medical Authorization
<input type="checkbox"/> Immunization and Physical Forms (Even if expiration occurs during summer)
<input type="checkbox"/> Medical Statement Page 1 (Can be left blank, if bringing in Immunization <u>and</u> Physical from doctor)
<input type="checkbox"/> Medical Statement Page 2 (Can be left blank, if bringing in Immunization <u>and</u> Physical from doctor)

If Child has known Allergy, Please proceed below

<input type="checkbox"/> Self-Medication Release Form
<input type="checkbox"/> Authorization for Administration Form



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January 2018

Re: Administration of Medication at YWCA Summer Camps

Dear Parent or Guardian,

Every effort should be made to administer medications outside of the YWCA Summer Day Camp settings. However, the designated Camp staff may administer medications under guidance of our Health Director, when needed, to support a camper's participation in the daily activities while at the YWCA summer program. The nurse is on site from 8:30am – 4:00pm.

The following is required for the administration of medicine:

1. Written order from a licensed physician for both prescription and non-prescription medications to be given at camp.
2. Self-administration form, signed by parent and physician. This is required for campers participating on trips, including Travel Camp.
3. The parent/guardian must assume responsibility to have the medication delivered directly to the Health Office in a properly labeled original container. For "over-the-counter" (non-prescription) medicines, the original store container must be labeled with the student's name and must have an expiration date on the manufacturer's label.

We ask that you pick up your child's medication by the last day of camp; medications left at the completion of camp will be discarded.

Thank you.

Camp Funkist Director



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YWCA SUMMER DAY CAMP PROGRAMS SELF-MEDICATION RELEASE FORM

Date: _____

Name of Camper (*please print*): _____

Date of Birth: _____

Camp Program attending: _____

Diagnosis: _____

Health Condition/Indication for Self-Medication: _____

Medication: _____ Dosage: _____

Route: _____ Time: _____

Duration of Treatment: _____

Possible Side Effects and Adverse Reaction (if any): _____

Other Recommendations: _____

The above named camper has been instructed in the proper use of the following medication procedures:

We request that the above named camper be permitted to carry and use the medication on his/her person. We consider the camper to be responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use for this medication.

Physician Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Camper Signature: _____ Date: _____

No camper will be permitted to carry/self-medicate a U.S. Drug Enforcement Agency designated controlled substance.



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AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION IN SUMMER CAMP

Camp Program: _____ Date: _____

A. To be completed by parent or guardian:

I request that my child, _____, receive the medication as prescribed below by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the Camp Health Director or designee will administer the medication.

Signature (Parent or Guardian) _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

B. To be completed by the licensed health care prescriber

I request that my patient receive the following medication:

Camper's Name: _____ Date of Birth _____

Diagnosis: _____

Name of Medication: _____

Dosage: _____ Frequency: _____

Time Taken in Camp: _____

Possible Side Effects and Adverse Reaction (if any): _____

Prescriber's Signature: _____

Date: _____

Physician's Stamp (Name & Address):



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REGISTRATION CONTACT FORM (Please print clearly. One form per child.)

Child's Name:	Date of birth: / /	Gender (circle): F M ___	T-SHIRT Size: _____
Address:			
Street	City	State	Zip
Nickname:	Grade child entering in Sept 2018:	Friends you wish to be with:	
Parent/Guardian Name:	Home Phone: ()	Cell: ()	
Address:	Email:		
Employer:	Work Phone: ()		
Parent/Guardian Name:	Home Phone: ()	Cell: ()	
Address:	Email:		
Employer:	Work Phone:		
<i>Below please list the individuals who should be called in an emergency and is authorized to pick-up your child.</i>			
<i>Emergency Contact #1 Name:</i>	<i>Relationship to child</i> <i>Emergency Phone #: ()</i>		
<i>Emergency Contact #2 Name:</i>	<i>Relationship to child</i> <i>Emergency Phone #: ()</i>		
<i>Emergency Contact #3 Name:</i>	<i>Relationship to child</i> <i>Emergency Phone #: ()</i>		

PERMISSION & INDEMNITY

As guardian of (Child's Name) _____, I, (Guardian's Name) _____ hereby give my child, permission to participate in Camp Funkist activities and events including, but not limited to the following:

- Trips
- Swimming
- Photo Taking

For campers with Epi-Pens and/or other medication, camper must be accompanied by parent or, provide a self-administration form, in order to go on off-site trips.

Photography and Publicity Release

I further grant permission to the YWCA White Plains & Central Westchester to use photographs, videotapes, and films of my child taken at the YWCA Camp Funkist program (or on trips) for publicity and promotion purposes.

Hold Harmless Statement

I hereby release and agree to hold harmless the YWCA White Plains & Central Westchester, its affiliates, insurers, attorneys, principals, directors, officers, agents, employees and volunteers ("The Released Parties") from any injury, loss, liability, damage or claims of any kind, including claims resulting from the negligence of any Released party that may arise out of or relate to my or my child(ren)'s participation in the YWCA to the greatest extent allowed by law. By signing this release, I clarify that I have read and agreed to this release and I fully understand it and am not relying on statements or representations of any Released party. Should I wish to exclude my child from any activity, I understand that I must notify the Camp Director in writing.

(PRINT) Parent/Guardian Name

(SIGNATURE) Parent/Guardian

Date



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2018 CAMP FUNKIST – TERMS OF REGISTRATION

1. Membership must be good **through the entire camp enrollment** to qualify for member rate. Membership fees are non-refundable.
2. Full payment or minimum \$250 NON-REFUNDABLE camp deposit is required to hold your spot.
3. Along with deposit, prior monthly payments are due upon signing if choosing payment plan option and starting payments after 3/15/18.
4. **All enrollment forms and documentation (including immunization form), must be completed by June 15, 2018.** No child will be allowed to participate unless **ALL** required medical forms, contact forms and releases have been submitted.
5. **No refunds are given for membership fees, deposits or program fees unless the YWCA cancels the program/class.** No refunds for cancellations due to weather. Documented medical disability may entitle patron to a pro-rate program fee.
6. All checks and money orders should be made payable to the YWCA. Please note your child's name and program on the check to facilitate proper recording. You may also elect to pay by credit card or cash.
7. **Camp Funkist offers two payment options: Full payment or 4-month payment plan.** *In order to authorize a payment plan, a valid credit card number must be included below. If payment is not made via alternate means by the 3rd of the month, the payment will automatically be charged to your credit card. If no credit card information is included, payment is due in full at time of registration.*
8. **All camp tuition must be paid in full by June 15, 2018 or enrollment will be cancelled.**
9. Additional camp policies are included in the Parent Handbook.
10. I understand that if another person is to pick up my child other than those identified above, I will give written permission to the Camp Director. I also understand that a photo ID is required to pick up my child.

I have read the Terms of Registration for my child's participation in Camp Funkist.

Parent/Guardian Name: _____ Signature: _____ Date: _____



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2018 Camp Funkist Contract & Fee Schedule

Child's First Name:		Child's Last Name:		Grade entering Sept 2018:	
Address:			City, State, Zip		
Weekly Fees		Week 1, 3-8 Member/Non-Member	Week 2 (per week) Member/Non-Member		
Astronauts	(turning 3 by December 31, 2018) 9AM-1PM	\$304 / \$329	\$243 / \$268		
Rockets	(turning 4 by December 31, 2018)	\$ 399 / \$ 424	\$ 319 / \$ 339		
Camp Funkist	Grades knd-6	\$399 / \$ 424	\$ 319 / \$ 339		
Teen Camp	(Grades 7th & Up)	\$405 / \$435	\$324 / \$348		
Breakfast Club	7:30 AM drop off. Cold breakfast included	\$55.00	\$40		
Early Morning	8 AM - 9 AM	\$ 42	\$ 37		
Rockets Late P/Up	3PM-4:00 PM	\$ 42	\$ 37		
Late Pick Up	4 PM - 6:00 PM	\$ 68	\$ 63		
C.I.T. Leadership	Age 15	\$130.00 per week	\$104		

Discount	Deadline	Savings*
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Returning Camper Priority Registration:	December 18, 2017 – January 7 th , 2018	
Early Bird Registration deadline:	March 10, 2018	save \$15/week
Payment in Full Savings (Good only when full payment is made for 4 or more weeks)		\$50 / camper

Note: Maximum of 2 discounts may be applied at any time.

Enrollment: Minimum of 3 weeks for Rockets; 2 weeks all other groups. **Check off weeks, early drop off and late pick-up.**

Camp Enrollment	Regular Camp Session	Breakfast Club 7:30 am	Early Drop Off 8 – 9AM	Rockets (only) 9-3PM	Rockets Late Pick 3-4 PM	Extended Day 4-6 PM
Week 1: 6/25 – 6/29						
Week 2: 7/2 - 7/6 *Camp closed on July 4 th						
Week 3: 7/09 – 7/13						
Week 4: 7/16 – 7/20						
Week 5: 7/23 – 7/27						
Week 6: 7/30 - 8/3						
Week 7: 8/6 – 8/10						
Week 8: 8/13 – 8/17						

Please indicate Camp Group:

<input type="checkbox"/> Astronauts	<input type="checkbox"/> Rockets	<input type="checkbox"/> Little Funkist (Kindergarten)
<input type="checkbox"/> All Stars (Grade 1)	<input type="checkbox"/> Blazers (Grade 2)	<input type="checkbox"/> Champions (Grade 3)
<input type="checkbox"/> Dynamos (Grade 4)	<input type="checkbox"/> Eagles (Grade 5)	<input type="checkbox"/> Funkist Plus (Grade 6)
<input type="checkbox"/> Teen Camp (Grade 7+)		<input type="checkbox"/> CIT (MUST be 15 years old)

FEES:

Weekly Tuition Subtotal:	\$ _____
Breakfast Club Subtotal:	\$ _____
Early Drop Off Subtotal:	\$ _____
Late Pick Up Subtotal:	\$ _____
Early Bird Discount (3/10/18):	\$ _____
Other discounts/Fees:	\$ _____
Total Fees (not including membership):	\$ _____

Full Payment _____(initial) Please charge my Visa / MC / Discover/ Amex below for the session fees listed above and membership.

4-Month Payment Plan _____(initial) Please charge my Visa / MC / Discover / Amex below for the camp deposit and annual youth membership fee (if paying for member camp rate). Please **automatically charge** my monthly camp payments to my Visa / MC / Discover / American Express on the 15th of the month.

CREDIT CARD INFORMATION

Cardholder's Name (Please print) _____ Signature _____
 Credit Card # _____ - _____ - _____ - _____ Expiration date: ____/____ Security Code _____

For Office use only

_____ - Deposit \$250 = \$ _____ (divided by 4) = _____
 Total Fees Balance Due Monthly Payment

Payments Due: Mar 2018 _____ Apr 2018 _____ May 2018 _____ Jun 2018 _____



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

Name of Child:	Date of Birth:	Date of Examination:
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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)	1 st Date	2 nd Date	3 rd Date	4 th Date	5 th Date
Polio (IPV or OPV)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Haemophilus influenzae type B (Hib)	1 st Date	2 nd Date	3 rd Date	4 th Date OR 1 st Date (if given on or after 15 months of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Hepatitis B	1 st Date	2 nd Date	3 rd Date		
Measles, Mumps and Rubella (MMR)	1 st Date	2 nd Date			
Varicella (also known as Chicken Pox)	1 st Date	2 nd 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.

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.

ADDITIONAL INFORMATION ON REVERSE SIDE →



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(continued)

Health Specifics	Comments
Are there allergies? (Specify) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is medication regularly taken? (Specify drug and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a special diet required? (Specify diet and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hearing, visual or dental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any medical or developmental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Summary of Physical Exam

Include special recommendations to 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 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.



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Camper First Name: _____ Last Name: _____

MEDICAL AUTHORIZATION

Please be advised that there are inherent risks related to the day camp program and its physical sports and other activities. There is the possibility of physical injury or damage to personal property. The safety of campers is the first priority of the day camp staff. If injured, your child will be taken to the nearest available hospital

Please read the statement below carefully: In the event of serious illness or injury, I authorize the day camp staff to transport my child to a hospital emergency facility for treatment. Every attempt to contact a parent or guardian will be made. I accept responsibility for the cost involved in the transport and treatment of my child.

I, _____ have read, understand, and agree with all of the above.
(Guardian's name)

Guardian's Signature

Date

MEDICAL CONTACT INFORMATION

Hospital Insurance Carrier _____

Child's Physician _____

Group/Hospital Name (if applicable) _____

Phone _____ Address _____

Child's Dentist _____

Group/Hospital Name (if applicable) _____

Phone _____ Address _____

FOOD ALERT

To ensure that your child is not given any food that he/she may be allergic to or should not eat for religious purposes please check below. If applicable, list all food restrictions.

- _____ My child has food restrictions for religious purposes
- _____ My child has food restrictions for medical reasons.
- _____ My child does not have any allergies of which I am aware.

My child may not eat the following foods: _____

DOES YOUR CHILD HAVE AN IEP OR 504 PLAN?

_____ Yes _____ No

The YWCA is committed to making reasonable accommodations for campers with disabilities that will impact their access and educational participation in YWCA programs and services. YWCA complies with and is guided by the provisions of the Americans with Disabilities Act (ADA) and its amendments. YWCA must be notified of any disabling condition that is likely to impact program participation.