



# Ready, Set, Camp! 2023

**\$700 before May 24<sup>th</sup>/\$750 after May 24<sup>th</sup>**

**\_\_\_Ward or \_\_\_Jefferson** (please check one)

All lines must be filled in on this registration form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_

What school does your child attend regularly? \_\_\_\_\_

Grade completed as of 6/23/23: \_\_\_\_\_ 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 well-being 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 you would like the Camp Staff to take into consideration? This extra information helps the camp staff better understand 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 5, 2023 – August 11, 2023 during normal camp hours (9:00a-4:00p[Early drop-off and Extended day: 8:00a-9:00a and 4:00p-5:00p]). The children will either walk or be transported by bus under the care and supervision of Camp Staff members. While every precaution will be taken to safeguard my child, it is understood that I release New Rochelle Parks and Recreation, City of New Rochelle, and its sponsoring agents from all responsibility, in case of accident or illness, including COVID-19 related illness while participating in this program.

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: \_\_\_\_/\_\_\_\_/2023

\*\*\*\*\*

**Please circle: EARLY DROP-OFF OR/AND EXTENDED DAY REGISTRATION**

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

**X** Signature:

Parent/Guardian Signature required here for Early Drop-Off and/or Extended Day (\$175 and/or \$175 – Both for \$300) starting at 8:00 am and/or ending at 5pm - 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 RECORDS ARE TO BE ATTACHED**

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 GENERALLY GOOD? \_\_\_\_\_

**ALLERGIES/SENSITIVITY**

HAS CHILD HAD, OR SUBJECT TO:

- |                 |       |                |     |
|-----------------|-------|----------------|-----|
| RHEUMATIC FEVER | ___   | FAINING SPELLS | ___ |
| SINUS TROUBLE   | ___   | POISON IVY     | ___ |
| EAR INFECTIONS  | ___   | INSECT STINGS  | ___ |
| CONVULSIONS     | ___   | PENICILLIN     | ___ |
| DIABETES        | ___   | OTHER DRUGS    | ___ |
| FOODS           | ..... | HAY FEVER      | ___ |
|                 | ..... | ASTHMA         | ___ |
| CHICKEN POX     | ---   |                |     |
| OTHER           | ..... |                |     |
|                 | ..... |                |     |

OPERATIONS OR SERIOUS 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: \_\_\_\_\_