SUMMER CAMP 2017 REGISTRATION

ALL CHILDCARE ACCOUNTS MUST BE UP TO DATE IN ORDER TO REGISTER.

RATES

<table>
<thead>
<tr>
<th>Camp: 9:00 AM - 4:30 PM</th>
<th>Extended Hours: 6:30-9 AM; 4:30-6 PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>$205/week **</td>
<td>$45/week</td>
</tr>
<tr>
<td>$195 – 2nd child</td>
<td>$40 – 2nd child</td>
</tr>
<tr>
<td>$185 – 3rd child</td>
<td>$35 – 3rd child</td>
</tr>
</tbody>
</table>

**Cost for Week 1 July 5-7 is $125.00, extended hours $27.00
Second child $120, extended hours $22.00**

DUE ON REGISTRATION DAY

Registration fee: $50.00 per child
Deposit: $25.00 per week, per child
Membership Fee (if expired): $30 (under 8) $40 (8 and up)
(The deposit amount will be deducted from your payments)

CAMP 2017 PAYMENT SCHEDULE

Payments for Camp will be due the Wednesday prior to the week of camp your child is attending.
If payment and late fee is not received by Friday, your child will not be allowed to come on Monday morning.

ALL DEPOSITS/REGISTRATION/MEMBERSHIP FEES ARE NON-REFUNDABLE

DEPOSITS MAY BE TRANSFERRED TO ANOTHER WEEK IF DONE BY MAY 15, 2017. IF CANCELLATIONS ARE NOT RECEIVED BY MAY 15, 2017, YOU WILL BE RESPONSIBLE FOR FULL PAYMENT.

LATE PICK-UP

There is a charge of $1.00 per minute, per child for parents picking up late. This fee is due immediately upon arrival. Please be aware that unexpected delays create anxiety for both your child and our staff.

NO CHILD WILL BE ALLOWED TO REGISTER WITHOUT AN ACTIVE MEMBERSHIP!

I have read, understand, and agree to the registration and payment policies of the Boys & Girls Club.

______________________________
Parent Signature

______________________________
Date
**SUMMER CAMP 2017 REGISTRATION FORM**

*Please fill out a form for each child*

Please print

Child’s Name ___________________________________________ Date of Birth ___ / ___ / ___

Address ___________________________________________ Apt # __________ City _______ State _______ Zip _______

Home # ___________________________ **Tee shirt size:** (circle) **Child** S M L **Adult** S M L XL XXL

Parent Name ___________________________ Parent Name ___________________________

Day Phone ___________________________ Day Phone ___________________________

Cell Phone ___________________________ Cell Phone ___________________________

E-mail ___________________________ E-mail ___________________________

Are there any custody issues/restraining orders? __________________________________________________________

Are there any medical issues we should be aware of? _______________________________________________________

Is any family member in the military *(membership fee will be waived after filling out enrollment form)* ____ yes ____ no

I give permission for my child’s photo to be taken for the Club website and/or local newspapers ____ yes ____ no

**Grade September 2017:**

(K 1ST 2ND 3RD 4TH 5TH 6TH 7TH 8TH)

*(Circle Grade)*

$50 registration per child (includes tee shirt)

$25 deposit per child, per week (deducted from payments)

Please check which weeks you will need.

<table>
<thead>
<tr>
<th>Week</th>
<th>Dates</th>
<th>Camp</th>
<th>Extended Hours</th>
<th>Deposit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>JULY 5-7*</td>
<td></td>
<td></td>
<td>$50.00</td>
</tr>
<tr>
<td>2</td>
<td>JULY 10-14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>JULY 17-21</td>
<td></td>
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<tr>
<td>4</td>
<td>JULY 24-28</td>
<td></td>
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</tr>
<tr>
<td>5</td>
<td>JULY 31-AUG 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>AUGUST 7-11</td>
<td></td>
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</tr>
<tr>
<td>7</td>
<td>AUGUST 14-18</td>
<td></td>
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</tr>
<tr>
<td>8</td>
<td>AUGUST 21-25</td>
<td></td>
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</tr>
</tbody>
</table>

*The Club will be closed July 3rd & 4th (price above)*

**STAFF USE ONLY**

Total Received

Cash (rec #)

Check (number)

Charge (ref. #)
SUMMER CAMP 2017
First Aid and Emergency Medical Care Consent Form

Please Print:
Child’s Name:___________________________________ Date of Birth:___/____/_____  

I authorize staff in the child care program, who are trained in the basics of first aid, to give my child first aid when appropriate. I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to (preferred medical facility), and to secure necessary medical treatment for my child.

Child’s Physician’s Name__________________________________ Phone #__________________

Address

Child’s allergies

Chronic health/psychological conditions

Special limitations/concerns

Health Insurance_________________________________________ Policy #__________________

Parent(s) name_________________________________________ Phone #__________________

Parent(s) name_________________________________________ Phone #__________________

Emergency Contacts:

I give permission for the following people to receive my child at the end of the day. If no one is authorized other than the parent/legal guardian, please indicate below “NO ONE.” If the child is protected by a restraining order, please submit a copy of the order along with this registration form.

1. Name______________________________________________ Relationship to child______________

   Address____________________________________________

   Work #____________________________________________

   Home #____________________________________________

   Cell #____________________________________________

2. Name______________________________________________ Relationship to child______________

   Address____________________________________________

   Work #____________________________________________

   Home #____________________________________________

   Cell #____________________________________________

3. Name______________________________________________ Relationship to child______________

   Address____________________________________________

   Work #____________________________________________

   Home #____________________________________________

   Cell #____________________________________________

______________________________________________________

Parent Signature________________________________________

______________________________________________________

Date__________________________________________________
PHYSICIAN’S FORM – MEDICAL EXAMINATION AND IMMUNIZATION HISTORY

MEDICAL EXAM AND IMMUNIZATIONS ARE DUE BY JUNE 1, 2017

You may substitute this for the standard form provided by the physician’s office.

Child’s Name__________________________________________________________

LAST  FIRST  MIDDLE

DOB ______/_____/______  Sex  □ Male  □ Female

Address________________________________________ City/Town_________________ State______ Zip Code________

Health Examination by Licensed Physician  Exam Date: ______/_____/______
Exam must be within 24 months preceding your child’s attendance in the summer program.

Allergies (bees, drug, environmental, etc)___________________________________________

Food Allergies_____________________________________________________________________

Is epinephrine prescribed?  □ Yes  □ No

Current medical problems, recent injuries, operations or chronic conditions________________________

Regular and/or periodic medications and reasons for taking them__________________________

Medication or treatment to be administered during the program period________________________

Additional Health Information________________________________________________________________

In my opinion, the condition of the above named program participant □ does allow  □ does not allow his/her participation in the summer program.

**YOU MUST ATTACH A RECORD OF IMMUNIZATION TO THIS FORM**

PLEASE NOTE:  NO CHILD REGISTERED IN A SUMMER PROGRAM WILL BE ALLOWED TO ATTEND THE PROGRAM WITHOUT A COMPLETE RECORD OF IMMUNIZATION.

FOR DOCTOR’S OFFICE ONLY:

Licensed Provider’s Signature________________________ Provider’s Name (please print)____________________

Address________________________________________ City/Town_________________ State______ Zip_______

Phone #_______________________________

Date Form Completed_____/_____/______  By__________________ (Initial if completed by nurse/physician’s assistant)

*You may substitute the standard form provided by the physician’s office.*