

## YMCA BUFFALO NIAGARA – DELAWARE FAMILY YMCA

Child's Name:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	Age as of July '09:	Grade as of Sept. '09:
Address, City, Zip:			Home Phone:	
Mother's Name:	Address, City, Zip:		E-mail:	
Mother's Occupation:	Date of Birth:	Day Phone:	Cell Phone:	
Father's Name:	Address, City, Zip:		E-mail:	
Father's Occupation:	Date of Birth:	Day Phone:	Cell Phone:	

**Select Camp:**    Delaware Day Camp    D'Youville Day Camp    Delaware Leaders in Training    Delaware Travel Camp  
                           UB Clark Hall Day Camp    Delaware Young Explorers    Delaware Counselors in Training   (8/31 - 9/4 only)

**Camp Hours:** 8:30 a.m. - 4:30 p.m.                      **Travel Camp:** 7:00 a.m. - 5:00 p.m.  
**Select Extended Hours:**    AM (7:00 - 8:30 a.m.)                      **T-shirt Size:** Youth   S   M   L  
     PM (Delaware & UB Clark Hall - 4:30 - 6:00 p.m.; D'Youville - 4:30 - 5:30 p.m.)                      Adult   S   M   L   XL  
     BOTH

### CAMP SESSIONS, THEMES & FIELD TRIPS – SELECT WEEKS ATTENDING (Themes & field trips subject to change without notice.)

<input type="checkbox"/> June 29 - July 3    Welcome to Camp	<input type="checkbox"/> Aug. 3 - 7            Outdoor Excitement <small>(Field Trip: Strong Museum/Camp Weona)</small>
<input type="checkbox"/> July 6 - 10            Patriot's Week <small>(Field Trip: Fort Niagara Pool)</small>	<input type="checkbox"/> Aug. 10 - 14        World of Play <small>(Field Trip: Strong Museum/Camp Weona)</small>
<input type="checkbox"/> July 13 - 17         Spirit Week <small>(Field Trip: Fantasy Island, YE-Bounce Magic)</small>	<input type="checkbox"/> Aug. 17 - 21        Camp Olympics <small>(Field Trip: Fishing Derby/Delaware Park, YE-Buffalo Zoo)</small>
<input type="checkbox"/> July 20 - 24         Lights, Camera, Action! <small>(Field Trip: Thruway Lanes/Movie Land 8)</small>	<input type="checkbox"/> Aug. 24 - 28        Fun in the Sun <small>(Field Trip: Evangola State Park)</small>
<input type="checkbox"/> July 27 - 31         Water Wonders <small>(Field Trip: Stony Brook State Park)</small>	<input type="checkbox"/> Aug. 31 - Sept. 4    Carnival Fun <small>(UB Clark Hall, Delaware Young Explorers &amp; Delaware Travel Camp only)</small>

### DAY CAMP WEEKLY COSTS (YMCA Member/Non-Member)

Delaware Day Camp: \$118/\$155	D'Youville Day Camp: \$90/\$120	Leaders in Training: \$115/\$135	Travel Camp: \$175/\$216.25
UB Clark Hall Day Camp: \$95/\$130	Delaware Young Explorers: \$120/\$159	Counselors in Training: \$115/\$135	

### PAYMENT INFORMATION

YMCA Member? <input type="checkbox"/> Yes <input type="checkbox"/> No	Deposit Enclosed: \$_____ (\$20 per week; \$10 per week before Feb. 28, 2009)
Membership Type: _____	<input type="checkbox"/> Check <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> Discover <input type="checkbox"/> AMEX
Exp. Date: _____	Card No: _____                      Exp. Date: _____                      Signature: _____
<input type="checkbox"/> Please send information	

### EMERGENCY CONTACT INFORMATION - If parents are unavailable in an emergency, please notify:

Name	Relation	Phone Number
Name	Relation	Phone Number
Names of individuals authorized to pick up child who are NOT listed above:		
Name	Relation	Phone Number
Name	Relation	Phone Number

### Field Trip Acknowledgement

I give my son/daughter \_\_\_\_\_ permission to attend all YMCA day camp field trips and/or overnights for the sessions that he/she is registered for. My child also has my permission to participate in swimming activities on field trips, including aquatic amusement park activities.

### Camper Information Form Content

I also acknowledge that the information stated above is accurate and factual.

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Return the completed form with deposit to: Delaware Family YMCA, 2564 Delaware Avenue, Buffalo, NY 14216.

Note: All deposits are non-refundable and non-transferable.

*Office use only:* Registration packet with receipt       Date: \_\_\_\_\_      Initials: \_\_\_\_\_

## MORE ABOUT YOUR CAMPER

Siblings Names & Ages:

Child's Swimming Ability (0 = Never Swam; 5 = Excellent):      0      1      2      3      4      5

Has child participated in YMCA progressive swim lessons?     No     Yes    When/What Level?

Child's favorite interests (games, sports, toys, hobbies):

May we use your child's picture in publicity photos?     Yes     No

Please list any additional information you would like us to know:

## CAMPER HEALTH HISTORY

The following information must be filled in by the parent/guardian. The intent of this information is to provide camp staff the background needed to provide appropriate care. Provide complete information so that the camp can be aware of your child's needs.

Allergies:	List Allergy:	Describe reaction and management:
<input type="checkbox"/> Medications (e.g. penicillin)		
<input type="checkbox"/> Food (e.g. eggs, dairy)		
<input type="checkbox"/> Other (e.g. insect stings, hay fever)		

**Medications:** Medications require a separate form. Please contact the camp director or staff for more information.

**Immunization History** - Please list the month, day, year administered

DPT Series	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	MMR	__/__/__	__/__/__
Tetanus/Diphtheria	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	or measles	__/__/__	__/__/__
Tetanus	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	or mumps	__/__/__	__/__/__
Polio OPV (Sabin)	__/__/__	__/__/__	__/__/__	__/__/__			or rubella	__/__/__	__/__/__
HIB Vaccine	__/__/__	__/__/__	__/__/__	__/__/__			Varicella	__/__/__	__/__/__
Hepatitis B	__/__/__	__/__/__	__/__/__				TB Mantoux Test	__/__/__	
Haemophilus Influenza B	__/__/__						TB Test Results	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative

## DOCTOR/INSURANCE INFORMATION

Is participant covered by family medical/hospital insurance?     Yes     No

Carrier/plan name:	Carrier Address:
Policy holder SS# or insurance ID #:	Group #:
Name of insured:	Relationship to participant:
Name of Family/Child Physician:	Physician Phone #:

## HEALTH HISTORY

Date of last physical:

### Has participant had:

1. Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	15. Recent injury, illness or infectious disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	16. Chronic or recurring illness/condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. German Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	17. Heart defect/disease/murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	18. Eating disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Hepatitis A/B/C	<input type="checkbox"/> Yes	<input type="checkbox"/> No	19. Diarrhea/constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20. Wear glasses, contacts or protective eye wear	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Frequent ear infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	21. Orthodontic appliance (e.g., retainer)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	22. Hypertension (high blood pressure)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	23. Emotional difficulties for which professional help was sought	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Seizures/Convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	24. Any specific activities that child cannot participate in or needs assistance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	25. Dizzy/passed out after physical activity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Head Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
13. Knocked unconscious	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
14. Skin Problems (e.g., itching rash, acne)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Please explain any "YES" answers, noting the number of the questions:

Any additional information about the participant's behavior and physical, emotional or mental health the camp should be aware of:

## PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE

I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

**Parent / Guardian Signature ONLY:**

**Date:**