

YMCA BUFFALO NIAGARA – NORTHEAST 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:	

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

Early Bird Camp: \$26.50/\$31.50 (Per day)	All-Arts & Specialty Camps: \$140/\$160	Sports Camp & Mini Sports Camp: \$84/\$96 (3-Day) \$140/\$160 (5-Day)
St. Leo & Clarence Day Camps: \$84/\$96 (3-Day) (Explorers, Trailblazers) \$140/\$160 (5-Day)	Young Explorers: \$84/\$96 (3-Day) \$140/\$160 (5-Day)	Travel Camp: \$180/\$200
Counselors in Training: \$320/\$370 (9 weeks)	Leaders in Training: \$140/\$160	Splash Camp: \$140/\$160

PAYMENT INFORMATION

YMCA Member? <input type="checkbox"/> Yes <input type="checkbox"/> No	Deposit Enclosed: \$ _____ (\$30 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: _____
<input type="checkbox"/> Please send information	Signature: _____

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: Northeast Family YMCA, 4433 Main Street, Amherst, NY 14226

Please Note: Application forms must be dropped off in person at the branch. Applications will not be accepted by fax or mail.

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: