# Town of Schodack

**Town Hall**
**265 Schuurman Road**
**Castleton, N.Y. 12033**

SHEILA GOLDEN
YOUTH DIRECTOR

TELEPHONE (518) 477-7590
FAX (518) 477-2439
e-mail: youthdirector@schodack.org

## Town of Schodack Day Camp Registration Form

Camp Dates July 9, 2018 – August 3, 2018

Child's Name_____Age___ Gender M__ F__
Grade your child will be in during the **18-19 school year**_____
Parent's Name_____
Address_____
Home Phone #_____Cell #_____Work # _____

Application forms must be returned to the Town Clerk's office at the Schodack Town Hall. Please enclose the registration fee of $125.00 for each child enrolled. For three or more children from the same family, there is a $325.00 maximum registration fee.

Make checks payable to: Town of Schodack Recreation.

There will be no refunds.

***All applications are due no later than May 31, 2018 – Please note the staggered start times!***

Please circle the appropriate site for your child:

C.E.S. (Grades K & 1) – 9:15 a.m. – 2:15 p.m.
C.E.S. (Grades 2 & 3) – 9:15a.m. – 2:15 p.m.
Maple Hill Middle School (Grades 4 & 5) - 9:30 a.m. – 2:30 p.m.
Maple Hill Middle School (Grades 6, 7, & 8) – 9:30 a.m. – 2:30 p.m.

**If your child holds a current swim level card, please attach a copy of it to this application**
**Special Group Requests**_____
**My child attends school in the following district Schodack_____East Greenbush____ Private_____**

**For Office Use Only**

Amount Paid _____ Check #_____Receipt #_____

Date Received_____ Received by_____

**Mail completed applications to: Sheila Golden/ Schodack Town Hall**
**265 Schuurman Rd. Castleton N.Y. 12033**

## Parent or Guardian Authorization

The health history provided to the Town of Schodack Day Camp is correct to my knowledge and the person herein described has my permission to engage in all camp activities, except those noted. In an event that I cannot be reached in an emergency, I hereby give my permission to the physician named on the health form, and/or the camp director to hospitalize and secure proper treatment for my child.

SIGNATURE_____DATE_____

Please notify the camp if this camper is exposed to any communicable diseases during the three weeks prior to camp attendance.

If anyone other than a parent will be picking your child up on a REGULAR basis, please list that name and give the necessary related information.

Name_____
Telephone number_____cell phone number_____
Relationship to camper_____

If your child is to go home with anyone not listed on the application, you must send a written note stating the name, date and written permission for camp to release your child to that person on the stated date.

## Schodack Youth Insurance Waiver Form

_____ (Print name of Parent or Guardian) does herby covenant and agree to release and hold harmless the Town of Schodack from and against any and all liability, loss, damage, claims, or actions (including costs of attorney fees) for bodily injury and/or property damage, to the extent permissible by law, arising from participation in the Town of Schodack's Youth Recreation Program.

I understand participation in the recreation program involves physical activity and risks of physical injury, and I assume these risks. I hereby give consent for emergency transportation and treatment in the event of illness or injury. I hereby accept responsibility for the payment of any emergency transportation or treatment on behalf of the participant. I further certify the participant is in good physical condition, and has no medical or physical conditions that would restrict his/her participation in the recreation program except as follows:

_____

(If no medical condition exists, please print the word "none" in the blank above.)

In the event that conditions exist, the applicant shall provide the Town with a physician's report, which identifies any restrictions or limitations the participant has before he/she is allowed to commence participation in the program.

I further understand the Town of Schodack is relying on my representations in this document.

Signature of Parent or Guardian_____Date_____

# Emergency Contact Form

**Please complete two emergency contacts**

Name_____

Address_____

Home Telephone _____Work Telephone_____

Cell Phone_____Other_____

Relationship to camper_____

Name_____

Address_____

Home Telephone _____Work Telephone_____

Cell Phone_____Other_____

Relationship to camper_____

Name of Doctor_____

Address_____

Telephone Number_____

In the event of an emergency, which hospital do you prefer?_____

Is there anything special you would like us to know about your child? If yes, please explain in the space below.

## Required Confidential Updated Health History

**Name** _____ **Grade Entering** _____

Health Problems - Please check all that apply

| | | | |
|---|---|---|---|
| _____Diabetes | _____Heart | _____Asthma | _____Headaches |
| _____Kidneys | _____Glasses | _____Vision | _____Seizures |
| _____Bladder/Bowel | _____ADD?ADHD | _____Hearing | _____None |

_____Allergies - if yes, please specify_____

EpiPen required _____Yes_____No (If yes, please supply the Director with an EpiPen, Emergency Kit and script signed by the Doctor and parent)

If yes to any of the conditions above, please describe in detail the health problem:

_____

Do health problems interfere with camp activities? _____Yes_____No. If yes, please explain:

_____

(Please supply Doctor Verification of restrictions)

Does your child take medication at camp? _____Yes_____No
Does Your child require medication at home? _____Yes_____No. If yes, please explain:

_____

Does your child know when and how to take his/her medication? _____Yes_____No
Any medication **must** have both Doctor and parent permission to be given.

Signature of Parent/Guardian_____Date_____

The Town of Schodack requires all immunizations required for school. Proof of immunization is required by the New York State Health Department. A signed copy (by the physician) of recent immunizations must be submitted with this application. All health information must be read by the camp nurse prior to the opening of camp. Immunizations cannot be submitted on the first day of camp.
The following immunizations must be complete:

| Vaccine | Date Administered |
|---|---|
| **DT-DTP-DTaP 1** | _____ |
| **DT-DTP-DTaP2** | _____ |
| **DT-DTP-DTaP3** | _____ |
| **DT-DTP-DTaP4** | _____ |
| **DT-DTP-DTaP5** | _____ |
| **DTP-Hib 1** | _____ |
| **DTP-Hib 2** | _____ |
| **DTP-Hib 3** | _____ |
| **DTP-Hib 4** | _____ |
| **Hib 1** | _____ |
| **Hib 2** | _____ |
| **Hib 3** | _____ |
| **Hib 4** | _____ |
| **Td 1** | _____ |

| Vaccine | Date Administered |
|---|---|
| **OPV IPV 1** | _____ |
| **OPV-IPV2** | _____ |
| **OPV IPV 3** | _____ |
| **OPV IPV 4** | _____ |
| **MMR 1** | _____ |
| **MMR 2** | _____ |
| **Hep B 1** | _____ |
| **Hep B 2** | _____ |
| **Hep B 3** | _____ |
| **Varicella** | _____ |

_____
**Physician's Signature**

**Required confidential Health History**

***** MUST BE RETURNED WITH CAMP APPLICATION*****

Name:_____Grade Entering:_____

**PLEASE CHECK IF YOU CHILD HAS ANY OF THE FOLLOWING:**

____Diabetes

____Seizure Disorder: Distat ____yes ____no

____Asthama: Inhaler at camp: ____yes ____no

____Food Allergy To:_____Epi Pen: ____yes ____no

____Bee Allergy: Epi Pen: ____yes ____no

____Vision Concern ____Hearing Concern ____Bladder/Bowel Concern

____Behavioral Concerns:_____

____Health problems that would limit physical activity (please describe below and provide a doctor's note)

____Medications at camp. Does your child know what, when and how to take their medication __yes __no

____**IMMUNIZATION FORM HAS BEEN ATTACHED TO CAMP APPLICATION**

Additional information regarding any of the above:_____

_____

********MEDICATIONS AT CAMP********

All medications need to be delivered to the Site Director **ON THE FIRST DAY OF CAMP.** The medications need to be in their original containers, have an order from the doctor, and signed permission from the parent/guardian. The medication and the orders **MUST BE IN CAMP ON THE FIRST DAY OR YOUR CHILD WILL NOT BE ABLE TO STAY.**

There will be a nurse at the camp site and at the pool. If needed, a nurse will be on field trips. There will not be a nurse on any of the buses. If your child has a medication that can only be administered by a nurse ( Diastat, Glucagon) and there is an emergency while on the bus , 9-1-1 will be called.

Parent Signature:_____Date:_____

TRANSPORTATION REQUEST FORM
Return this transportation form with application

Dear Parent or Guardian,

In the spaces below please indicate the pick up and drop off sites for a.m. and p.m. for your child.

A.M. pick up Location include bus #

_____

Please circle A.M. drop off site: Castleton Elementary or Maple Hill Middle School

P.M. drop off Location include bus #

_____

Parent or Guardian Name _____

Camper's home address _____

Camper's home phone number _____

**Please include an emergency number where you can be reached.** _____

**Please list any persons responsible for picking up your child and their phone number.**

_____ **phone #** _____

_____ **phone #** _____

_____ **phone #** _____

_____ **phone #** _____

**CAMPER'S NAME:** _____

PLEASE CIRCLE CAMP SITE

CES (grades K and 1)

CES (grades 2 and 3)

MHMS (grades 4 and 5)

MHMS (grades 6 – 8)