



Town of Schodack

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

SHEILA GOLDEN
YOUTH DIRECTOR

TELEPHONE (518) 477-7590
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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) – 9:15 a.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 hereby 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

- | | | | |
|---|-----------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart | <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Kidneys | <input type="checkbox"/> Glasses | <input type="checkbox"/> Vision | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bladder/Bowel | <input type="checkbox"/> ADD?ADHD | <input type="checkbox"/> Hearing | <input type="checkbox"/> None |
| <input type="checkbox"/> 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:

<u>Vaccine</u>	<u>Date Administered</u>	<u>Vaccine</u>	<u>Date Administered</u>
DT-DTP-DTaP 1	_____	OPV IPV 1	_____
DT-DTP-DTaP2	_____	OPV-IPV2	_____
DT-DTP-DTaP3	_____	OPV IPV 3	_____
DT-DTP-DTaP4	_____	OPV IPV 4	_____
DT-DTP-DTaP5	_____		
DTP-Hib 1	_____	MMR 1	_____
DTP-Hib 2	_____	MMR 2	_____
DTP-Hib 3	_____		
DTP-Hib 4	_____	Hep B 1	_____
		Hep B 2	_____
Hib 1	_____	Hep B 3	_____
Hib 2	_____		
Hib 3	_____	Varicella	_____
Hib 4	_____		
Td 1	_____		

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)

MHMS (grades 4 and 5)

CES (grades 2 and 3)

MHMS (grades 6 – 8)