

Regional YMCA of Western Connecticut- Camp Greenknoll
2009 REGISTRATION FORM (pg. 1)
Camper Information

First Name: _____ Last Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Gender: _____ Grade Entering In The Fall: _____ With whom does the child reside? _____

Please list any allergies, special diet, health needs or other information that may affect your camper's attendance to camp: _____

Parent/Guardian Information

Mother's Name: _____

Father's Name: _____

Address: _____

Address: _____

Home Phone: _____

Home Phone: _____

Employer: _____

Employer: _____

Work Phone: _____

Work Phone: _____

Cell Phone/Pager: _____

Cell Phone/Pager: _____

Please describe any custody or visitation restrictions: _____

PARENT/GUARDIAN AUTHORIZATION FOR PARTICIPATION AND HOSPITALIZATION IN THE EVENT OF AN EMERGENCY

I give permission for my child to participate in all Regional YMCA activities. I certify that my son/daughter is amenable to discipline and free from habits or attitudes which would make him/her an unsuitable camper. I also authorize the YMCA to have and use photographs, slides, or videotapes of the person named on this application. I also give permission for photographs of my child to be used for publicity purposes.

I understand that all children must be picked-up by 6:30 p.m. There is a charge of \$1 per minute for late pick-ups. I understand that I am financially responsible for all camp costs for my child. I have read and understand the payment/refund/credit policy and will inform the YMCA of any changes to my child's attendance in writing at least ten (10) days prior to the change. I am aware that there must be a current physical form on file in order for my child to participate. In the event I cannot be reached in an emergency, I hereby give consent to the staff of The Regional YMCA of Western Connecticut or competent authority to access emergency medical care and/or transportation to the hospital.

X _____
Parent/Guardian's Signature Date

Emergency Contact Information and Pick-up Authorization

Please list the names and phone numbers of emergency contacts for your child in the event that you are unable to be reached in an emergency. The following individuals will also be authorized to pick-up your child from camp.

1. Name: _____ Home Phone: _____

Address: _____

Work Phone: _____ Cell Phone/Pager: _____

2. Name: _____ Home Phone: _____

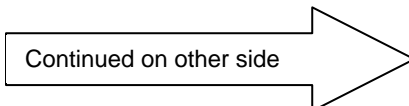
Address: _____

Work Phone: _____ Cell Phone/Pager: _____

3. Name: _____ Home Phone: _____

Address: _____

Work Phone: _____ Cell Phone/Pager: _____



Regional YMCA of Western Connecticut- Camp Greenknoll

2009 REGISTRATION FORM (pg. 2)

Camper Information

Camper's Name: _____ Grade Entering in the Fall: _____

Please indicate which program(s) your camper will be attending:

YMCA Camp Greeknoll Programs:

	Program	Ages	Price per week	Week of 6/29 *closed Friday 7/03
_____	Regular Day Camp	5-12	\$240	\$192
_____	Half-Day Pre-School (9-12:30)	3-4	\$170	\$136
_____	Full-Day Pre-School	3-4	\$250	\$200
_____	C.I.T. Program	13-14	\$170	\$136

Please indicate what week(s) your camper will be attending:

- Week 1 _____ 6/15-6/19
- Week 2 _____ 6/22-6/26
- Week 3 _____ 6/29-7/2 *Closed 7/03
- Week 4 _____ 7/6-7/10
- Week 5 _____ 7/13-7/17
- Week 6 _____ 7/20-7/24
- Week 7 _____ 7/27-7/31
- Week 8 _____ 8/3-8/7
- Week 9 _____ 8/10-8/14
- Week 10 _____ 8/17-8/21

Additional Programs- Specialty Camps- Ages 11-13

Escape to the Arts (9am – 12 noon)- Campers will be bused to and from Escape to the Arts daily for our half-day specialty camp programs. The cost per week is \$140.00. If you wish to have your camper attend Camp Greenknoll for the remainder of the day there is an additional \$130 charge per week.

	Program	Week	Price	Extended Day Additional \$130	
_____	Pottery	7/6-7/10	\$140	YES	NO
_____	Cartooning	7/13-7/17	\$140	YES	NO
_____	Jewelry	7/20-7/24	\$140	YES	NO
	Making			YES	NO
_____	Oil Painting	7/27-7/31	\$140	YES	NO

Great Hollow Wilderness School (9am -4pm) **CAMP F.O.L.L.O.W. Two-Week Program** This camp will be held at Camp Greenknoll for the first week and campers will be bused to and from Great Hollow Wilderness School in New Fairfield for the second week. Please see our brochure for additional details

	Program	Week	Price
_____	Camp FOLLOW	7/27-7/31 & 8/3-8/7	\$530

Regional YMCA of Western Connecticut
Camp Greenknoll
2009 PAYMENT SHEET

Camper's Name: _____ Date of Birth: _____

INITIAL PAYMENT:

Membership: If your camper is not a member of the Regional YMCA or their membership expires prior to 9/1/09 there is a \$55 membership fee.

Membership Fee: _____

Camp Improvement Fee: \$10 per child per summer

\$10.00

Weekly Fees: Payment for the first two weeks of enrollment is due at the time of registration. The remaining weeks may either be paid at the time of enrollment or in accordance with the post-dated schedule below.

First week of enrollment _____

Second Week of Enrollment _____

Additional weeks (optional) _____

Late Fee: Any registrations received after Wednesday for the following week are subject to a \$40 late fee. This includes both new registrations and additional weeks added to current registrations.

LATE FEE: _____

TOTAL INITIAL PAYMENT: _____

Payment Method:

Cash _____

Check _____ Check # _____

Credit Card: _____

Card Holder's Name: _____ Billing Zip Code: _____

Card #: _____ Exp. Date: _____

Signature: _____ Date: _____

POST-DATED PAYMENTS: The following is a payment schedule for the remainder of the summer. All credit/debit card charges will be made in accordance with the schedule below. Your child will not be registered for any weeks which payment or post-dated payment information has not been received. Please note that this schedule is strictly for the use of credit/debit cards ONLY. Please see the parent handbook for more information.

Week	Payment Date	Week	Payment Date
6/29-7/2	6/24	7/27-7/31	7/22
7/6-7/10	7/1	8/3-8/7	7/29
7/13-7/17	7/8	8/10-8/14	8/6
7/20-7/24	7/15	8/17-8/21	8/13

Credit/Debit Card Information:

Card Holder's Name: _____ Billing Zip Code: _____

Card #: _____ Exp. Date: _____

I give permission for the Regional YMCA of Western Connecticut to use the credit card above to make post-dated payments for YMCA Camp Greenknoll. I understand that charges will be made to my credit card according to the schedule stated below.

Signature: _____ Date: _____

**Regional YMCA of Western Connecticut
Greenknoll Day Camp
2 Huckleberry Hill Road
Brookfield, CT 06804
HEALTH FORM**

Before June 10, 2009
Phone: (203) 775-4444
Fax: (203) 740-9289

After June 10, 2009
Phone: (203) 775-9363
Fax: (203) 740-3639

EMPLOYEE NAME _____
 Date of Birth _____ Home Phone _____ Cell Phone _____
 Address _____

TO BE COMPLETED BY A MEDICAL PRACTITIONER:
A physician must have completed a physical examination within the last 36 months.

_____ May participate in all camp activities
 _____ May participate except for:

Date of Exam _____

Medical information pertinent to routine care and emergencies: _____

Is this individual taking prescription medication? YES NO
 If yes, indicate prescription: _____

Does the individual have allergies? YES NO Explain: _____

Is the individual on a special diet? YES NO Explain: _____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

Comments:

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care providers: City/Town _____ ST _____ Zip Code _____

 Signature of Physician, APRN or PA

 Date Form Signed

 Telephone Number

Regional YMCA of Western Connecticut - Camp Greenknoll
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY
YOUTH CAMP PERSONNEL

THIS FORM MUST BE COMPLETED FOR EVERY PRESCRIPTION MEDICATION AND DAILY OVER-THE-COUNTER MEDICATION REQUIRED BY A PHYSICIAN. A SEPARATE FORM IS REQUIRED FOR EACH MEDICATION.

If a Youth Camp chooses to administer prescription medications, the Connecticut State Law and Regulations require an authorized prescriber (M.D., P.A., APRN) or dentist's written order and parent or guardian's authorization for a nurse or camp personnel with current Medication Administration Training to administer medications. Prescription medication must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber or dentist's name and date of the original prescription. Over the counter medications must be in the original container and labeled with the child's name.

AUTHORIZED PRESCRIBER OR DENTIST'S ORDER: Date ____/____/____

Name of Child _____ Date of Birth ____/____/____

Street Address _____ City/Town _____ State _____

Condition for which drug is being administered during camp _____

Drug: Name of Drug, Dose, and Method of Administration _____

Times of Administration: _____, _____, _____ Medication shall be administered from ____/____/____ - ____/____/____

Relevant side effects to be observed, if any: _____

If there are side effects, plan for management: _____

Is this a controlled drug? _____ Yes _____ No Is this drug self-administered? _____ Yes _____ No

Allergies, reaction to, or negative interaction with food or drugs? If YES, list _____

Authorized Prescriber's or Dentist's Name _____ Phone # (____) _____ - _____

(Print or Type)

Street Address _____ City/Town _____ State _____

Authorized Prescriber or Dentist's Signature _____ Date ____/____/____

Authorization by Parent/Guardian for the administration of the above medication:

Date: ____/____/____

I hereby request that the above medication, ordered by the authorized prescriber/dentist for my Child,

_____, be administered by the nurse or by camp personnel with current Medical Administration

Training. I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by an authorized prescriber, dentist or pharmacist. Over the counter medications shall be in the original container labeled by the parent with the child's name.

I understand that this medication will be destroyed if it is not picked up within one (1) week following termination of the order.

Name of Parent/Guardian _____ Signature _____

Relationship to child _____ Street Address _____

City/Town _____ State _____ Zip Code _____ Phone (____) _____ - _____