SHOREFRONT
YM-YWHA OF BRIGHTON - MANHATTAN BEACH, INC.

Mini Camp Registration

December 24th - 28th **February 18th - 22nd**

For office use only
Medical Form

Date_____

Child's Name

_____ Birth Date _____/_____/_____ Age _____ Sex: F M
First Last

School Name _____ Grade _____

Does Child Attend Other Shorefront Y Programming? _____

Second Child's Name

_____ Birth Date _____/_____/_____ Age _____ Sex: F M
First Last

School Name _____ Grade _____

Does Child Attend Other Shorefront Y Programming? _____

Daily and Weekly Rates

BEST PRICE

Any 1 Day $85	Any 2 Days $170	Any 3 Days $255	Any 4 Days $340	Any 5 days $400

Please note you cannot combine December and February. They are sold separately.
Circle all days you plan to attend.

December 8:00am - 6:00pm	**12/24**	**12/25**	**12/26**	**12/27**	**12/28**
Extended Day 6:00pm - 7:00pm $10 per day	**12/24**	**12/25**	**12/26**	**12/27**	**12/28**
February 8:00am - 6:00pm	**2/18**	**2/19**	**2/20**	**2/21**	**2/22**
Extended Day 6:00pm - 7:00pm $10 per day	**2/18**	**2/19**	**2/20**	**2/21**	**2/22**

*****Late arrival policy fee: For arrival after 6:00pm, a fee of $20 will be charged, unless the late stay option was selected and paid for in advance.**

Sibling Discount: Register first child and receive a **7% discount** towards second child's program fee

TERMS OF ENROLLMENT

1. Mini Camp Fees are non-refundable.
2. There is a **$35 fee** for any bounced checks.
3. Please keep in mind that there is a late pick up fee of $20 if your child is not picked-up on time.
4. I understand that Shorefront Y reserves the right to suspend or terminate a child's enrollment due to unacceptable behavior issues without a refund.

Signature of Parent or Guardian _____ **Date** _____

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FAMILY INFORMATION

Parent Name	Cell Phone	Work Phone	E-mail address Required

Home Address_____ Apt #_____

City_____ State _____ Zip _____

Health Insurance:

Company and Policy # _____

Family Doctor _____ Phone_____

Emergency Contacts (other than parents):		Phone	Relationship
Full Name			
Full Name			

Authorized Pickups* (other than parents):		Phone	Relationship
Full Name			
Full Name			
Full Name			
Full Name			

*** Your child will NOT be allowed to leave with a person whose name is not listed above.** Please list **ALL** persons allowed to pick up your child from program. Siblings under age of **16** will not be allowed to pick up the child.

How did you find out about our Mini Camp?

□Friend _____ □Newspaper (please specify)

_____

□Flyers □Radio □Email from us □Shorefront Y website

□Other (please specify) _____

New participant(s): □Yes □ No, this will be my child's _____year at the Shorefront Y Winter Camp Program

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Required Waivers

Photo Release

I hereby grant permission, without reservation, to the Shorefront YM-YWHA and the United Jewish Appeal-Federation of Jewish Philanthropies of New York, Inc, ("UJA-Federation"), and those authorized by the Shorefront YM-YWHA and UJA-Federation, to take photographs and to make recording of me and my child and to use them in original or modified form in all media now or hereafter known, with or without my or my child's name or information about me or my child, for the promotion, public education, and/or fundraising activities of both organizations. I understand and agree that I am entitled to receive no compensation for the above.

I release The Shorefront YM-YWHA and UJA-Federation its officer, director, agents, employees, independent contractor, licensees and assignees from all claims that I now have or in the future may have relation to the above.

I agree that The Shorefront YM-YWHA and UJA-Federation will be the sole owners of all tangible rights in the above mentioned photographs and recording, will full power of disposition.

I am the parent or guardian of the minor named above, and I hereby consent to the foregoing on behalf of the minor and myself.

Signature _____

Administration of Medicine/Medical Release Agreement

The medical form is due before the start of the program; no child will be allowed to start before a complete medical form is on file. Based on Office of Children and Family Services regulations, our staff CAN NOT administers medication at any time. If your child needs to take medication during Mini Camp hours, YOU must make other arrangements. Students may not carry their own or other medication to the program. Students are permitted to store an inhaler for asthma at the site, provided inhaler is in original box with instructions.

I, give my permission for my child to receive whatever emergency medical care that may be deemed needed by Shorefront Y Mini Camp personnel for the treatment of any injury that may be incurred while in the program's activities or swimming on premises or elsewhere. I understand Shorefront Y Mini Camp will make effort to contact myself or my emergency contact before or immediately after such emergency treatment is rendered.

Signature _____

Activity/ Trip & Transportation Release

I hereby grant permission, without reservation for my child to participate in all activities and attend all trips with the Shorefront Y Mini Camp.

As parent/guardian of the above named child/children, I hereby release the Shorefront Mini Camp from all liability arising out of his/her transportation throughout all the extra curriculum activities, including trips.

Signature _____

Waiver of Liability

The Shorefront YM-YWHA provides service for children during the 2018-2019 school year. Our staff is trained to provide the maximum level of protection for your child while in our care. Even with all of these safeguards, injuries can occur. As a parent or legal guardian of the above named student, I fully understand the risks involved in my child's participation in the all program activities. To the best of my knowledge, my child has no medical conditions, which would conflict with his/her participating in the Shorefront Y Mini Camp educational, sport and recreation programs. I further agree to waive the right to press legal charges against Shorefront YM-YWHA in those instances where any of the above have not clearly demonstrated negligence leading to injury of the above named student.

Signature _____

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Swimming Consent

I, the parent or guardian of the minor named above, give permission for my child to go swimming in the Shorefront YM-YWHA pool for the duration of their attendance in the Shorefront Y Mini Camp.

Signature _____

Climbing Wall Consent

I, the parent or guardian of the minor named above, give permission for my child to participate in the climbing wall unit activity at the Shorefront Y.

Signature _____

Special Needs

We make every effort to accommodate the children we serve in our programs. If your child has an IEP (Individual Educational Plan), please speak to the director of the program before registering in order to assure the best experience for your child in the Mini Camp. Please understand that if you do not provide the most recent copy of your child's IEP at the time of registration, and will not communicate your child's unique needs to the Shorefront Y ASP management, we reserve the right to terminate our services for your child.

Signature _____

Parent Agreement

- The Shorefront YM-YWHA will not be responsible for any lost, stolen, or damaged property.
- The Shorefront YM-YWHA reserves the right to use all pictures taken for publicity purposes.
- The Shorefront YM-YWHA reserves the right to terminate the program for any participant who exhibits serious and persistent behavioral pattern and may pose a risk to him/herself and/or others. The Director will be in communication with families of any child exhibiting problematic behaviors. **No refund will be issued for termination due to behavioral issues.**
- The Shorefront YM-YWHA reserves the right to suspend and/or expel any child/children who are caught breaking any of the program rules. **NO refund will be given if a child is expelled from the Shorefront Y Mini Camp**.

Each participant of the Shorefront YM-YWHA Mini Camp is expected to:

1. Follow the program's rules.
2. Respect the Beliefs, Rights and Property of other participants.
3. Resolve conflicts peacefully without fighting or name calling.
4. Be respectful and courteous to All Mini Camp Staff.
5. Never leave/walk away from the group.
6. Address all issues with staff if a problem were to arise.
7. Take proper care of all Shorefront Y rooms, the contents of the rooms, and all property belonging to the Shorefront Y.

Parents / guardians of a child in the Shorefront YM-YWHA Mini Camp are expected to:

1. Talk with the Director/ Upper Staff about your child's behavior issues and address them at home with your child.
2. To follow recommendations made by the Director concerning your child's development.
3. Be on time every day to pick up your child at dismissal time.

- **Children are not allowed to bring in electronic games, IPods, cell phones or any other type of electronic game or any other types of toys. We strongly encourage all students to leave all valuables at home. These items will be confiscated.**
- I understand that Shorefront Y has a strictly Kosher food policy as well as Nut Aware policy. Any food that is brought in for the groups such as birthday party celebrations or any shared treats must be approved in advance by the director, the food must be kosher and nut free.

I have completed the form to the best of my knowledge and fully accept the terms of enrollment.

Signature _____ **Date**_____

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Child's Name_____

For Office use only:

Discounts:

Reason for a Discount _____ Amount: $_____

For Office use only:

	Camp Fee		Early drop off/ Late Stay		Total		AMOUNT DUE
Child 1	$	+	$	=	$	=	$
Child 2	$	+	$	=	$	=	$
	$	+	$	=	$	=	$

For Office use only:

Payment history			
Amount paid	**Receipt #**	**Payment Date**	**Comments**
$			
$			
$			
$			

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS ☐☐☐☐☐☐☐☐☐☐

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* __ __ / __ __ / __ __ __ __

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough | State | Zip Code | School/Center/Camp Name | District Number __ __ __ | **Phone Numbers** *Home* _____ *Cell* _____ *Work* _____

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** ☐ **Foster Parent** | Last Name | First Name

TO BE COMPLETED BY HEALTH CARE PROVIDER

If "yes" to any item, please explain (attach addendum, if needed)

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

Dietary Restrictions

☐ None ☐ Yes *(list below)*

PHYSICAL EXAMINATION

Height _____ **cm** (___ ___ %ile)

Weight _____ **kg** (___ ___ %ile)

BMI _____ **kg/m²** (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

	NI	Abnl
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

SCREENING TESTS

	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__ __ / __ __ / __ __	_____ µg/dL
	__ __ / __ __ / __ __	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__ __ / __ __ / __ __	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__ __ / __ __ / __ __	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__ __ / __ __ / __ __	_____ g/dL
	__ __ / __ __ / __ __	_____ %

	Date Done	Results
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__ __ / __ __ / __ __	Induration _____mm
PPD/Mantoux *read*	__ __ / __ __ / __ __	☐ Neg ☐ Pos
Interferon Test	__ __ / __ __ / __ __	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__ __ / __ __ / __ __	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__ __ / __ __ / __ __ ☐ with glasses	Acuity *Right* ___ / ___ *Left* ___ / ___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES

CIR Number of Child ☐☐☐☐☐☐☐☐☐

Hep B	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Rotavirus	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	
DTP/DTaP/DT	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	
Hib	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
PCV	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Polio	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __

Influenza	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
MMR	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	
Varicella	__ __ / __ __ / __ __	__ __ / __ __ / __ __		
Td	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	
Tdap __ __ / __ __ / __ __	Hep A	__ __ / __ __ / __ __	__ __ / __ __ / __ __	
Meningococcal	__ __ / __ __ / __ __	__ __ / __ __ / __ __		
HPV	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	
Other, *Specify:* _____	__ __ / __ __ / __ __ ;	_____	__ __ / __ __ / __ __	

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __ __ / __ __ / __ __

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

_____ __ __ __ __

_____ __ __ __ __

_____ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __ __ __

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

DOHMH ONLY **PROVIDER I.D.** ☐☐☐☐☐☐☐

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: __ __ / __ __ / __ __ | **I.D. NUMBER** ☐☐☐☐☐☐☐

REVIEWER:

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian