Mayor Kelly A. Yaede

CYO / BROMLEY NEIGHBORHOOD CENTER

1801 East State Street
Hamilton, New Jersey 08609
(609) 587 - 8100 (609) 587 - 9601 Fax
cyobromley.org

ANNOUNCES

2018 CYO Bromley Summer Camp

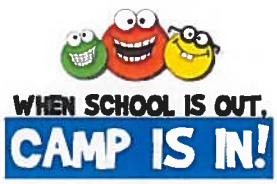
Who:	5 - 9 year olds
What:	8 Week Summer Camp Program
Where:	CYO Bromley Neighborhood Center 1801 East State Street, Hamilton NJ 08609
When:	June 25th - August 17th, 2018 Monday to Friday, 7:30am - 5:30pm
Fee:	$80 per week $600 for all 3 weeks Includes lunch afternoon snack, and a camp T-Shirt Field Trips included in the price.

*** Child Care Connection vouchers are accepted.**

Contact us for more information including a registration form

609-587-8100

phardiman@cyomercer.org



www.cyobromley.org

CYO/BROMLEY SUMMER DAY CAMP

2018 REGISTRATION

8 week Summer Camp Program from June 25-August 17 for 5-9 year olds 7:30am-5:30pm

Name of Child	Age	Date of Birth	Male ☐ Female ☐
Address		City	
School		Grade Entering in Fall	
Mother's Name		Father's Name	
Home Phone #		Home Phone #	
Work Phone #		Work Phone #	
Cell Phone #		Cell Phone #	
Employer		Employer	

Rates/Selection

____ Whole Summer (June 25-August 17) **$600.00**

____ Weekly (check below, weeks you will be attending) **$85.00**

____Week of 6/25 ____Week of 7/23

____Week of 7/2 ____Week of 7/30

____Week of 7/9 ____Week of 8/6

____Week of 7/16 ____Week of 8/13

Discounts: $25 discount for multiple children for 8 week Registration only

All initial registrations must be accompanied by a $50.00 registration fee. Registration fee is per family for new campers only and is non-refundable. Registration takes place at CYO/Bromley Center, 1801 East State St.

Office hours 8:00am-4:00pm Mon. – Fri.

There are NO REFUNDS FOR MISSED DAYS, ILLNESSESS, VACATIONS, OR DISMISSAL FOR DISCIPLINARY REASONS.

All forms must be submitted and completed before a camper is considered fully registered.

Refund Policy
100% refund given until March 31, 2018
75% refund given until April 30, 2018
50% refund given until May 31, 2018
NO REFUND given after May 31, 2018

Lunch & Afternoon Snack included. Child Care Connection Vouchers accepted

FOR CREDIT CARD PURCHASES ONLY:

NAME OF CREDIT CARD _____

CARD NUMBER: _____ Exp. Date: _____

SIGNATURE: _____ Total Amount of Charge $ _____

(over)

Food Allergies

Please list any food allergies, health issues, or special circumstances that we should be aware of:

_____

_____

_____

_____

_____

Acknowledgement of Risk/Wavier and Release

I certify that my child's physical condition is satisfactory for participating in the above CYO Program. I recognize that there are certain risks of physical injury in any activity and I hereby assume full responsibility for any expenses incurred as a result in my child's participation in the CYO Summer. I agree to A) waive and relinquish: B) fully release and discharge; and C) indemnify and hold harmless the CYO of Mercer County, CYO Bromley Neighborhood Community Center, and Hamilton Township and their officers, agents, and employees from any and all claims from injuries, damage or loss which may accrue to me on account of my child's participation in the CYO Bromley Summer Food Service Program.

_____

Signature of Parent or Guardian Date

Photo/Video Release

I give_____/do not give_____the CYO Bromley permission to use any photographs or video of my child for any promotional or other legitimate reason, including newspapers, brochures, website, Facebook, etc.

_____

Signature of Parent or Guardian Date

Permission to Treat

Campers Name:_____

Emergency Information

Primary Care Physician:_____

Contact Phone Number:_____

In the event of an emergency please contact:

Name:_____

Relationship to Camper:_____

Phone Number:_____

Emergency Medication

TYLENOL/MOTRIN- In case of an extreme emergency and a medical professional instructs the CYO Bromley Camp Staff to administer Tylenol/Motrin on site, I hereby give permission for the staff member to administer this medication. The instructed dosage will be given according to the camper's age and weight.

BENEDRYL – If the camper has an extreme allergic reaction during the course of the camp day, I hereby give permission for a staff member of the CYO to administer Benedryl if they are instructed by a medical professional to do so. The instructed dosage will be given according to the camper's age and weight.

Emergency Authorization

I hereby give permission to any physician selected by the CYO Bromley to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery.

_____

Signature of Parent or Guardian Date

For Office Use

Year

Cabin or Group

Name

Health History and Examination Form for Children, Youth and Adults Attending Camps

FM 08N

Suggested for resident camp use.

Developed and approved by
American Camping Associatione
American Academy of Pediatrics

Dates of Camp Attendance_____

Mail this form to the address below by_____(date)

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians of minors or by adults themselves. Update required annually. Health exam (back page) must be completed by approved licensed medical personnel at least every two years.

Name_____ Birth date_____ Age at camp_____
Last First Middle

Home address _____
Street address City State Zip

Social security number of participant_____ Gender: ☐ Male ☐ Female

Custodial parent/guardian _____ Phone _____

Home address _____
(If different from above) Street address City State Zip

Business address _____ Phone _____
Street address City State Zip

Second parent or guardian or emergency contact _____

Address _____ Phone _____
Street address City State Zip

Business address _____ Phone _____

If not available in an emergency, notify:

Name _____

Relationship _____ Phone _____

Address _____
Street address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? ☐Yes ☐No

If so, indicate carrier or plan name_____ Group # _____

▶ **Photocopy of front and back of health insurance card must be attached to this form.**

Important — These boxes must be complete for attendance*

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staffer _____

Printed Name_____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer_____ Date _____

*If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Health History

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies (list)

_____ _____

_____ _____

_____ _____

_____ _____

Food allergies (list)

_____ _____

_____ _____

_____ _____

Other allergies (list) — include insect stings, hay fever, asthma, animal dander, etc.

_____ _____

_____ _____

_____ _____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person takes NO medications on a routine basis.

☐ This person takes medications as follows:

Med #1_____Dosage_____Specific times taken each day _____

Reason for taking _____

Med #2_____Dosage_____Specific times taken each day _____

Reason for taking _____

Med #3_____Dosage_____Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications.
Identify any medications taken during the school year that participant does/may not take during the summer: _____

_____

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

☐ Does not eat red meat ☐ Does not eat pork ☐ Does not eat eggs

☐ Does not eat poultry ☐ Does not eat seafood ☐ Does not eat dairy products

☐ Other (describe) _____

_____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

_____

_____

General Questions (Explain "yes" answers below.)

Has/does the participant:	Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever passed out during or after exercise?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐
14. Ever had high blood pressure?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐
16. Ever had back problems?	☐	☐
17. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
18. Have an orthodontic appliance being brought to camp?	☐	☐
19. Have any skin problems (e.g., itching, rash, acne)?	☐	☐
20. Have diabetes?	☐	☐
21. Have asthma?	☐	☐
22. Had mononucleosis in the past 12 months?	☐	☐
23. Had problems with diarrhea/constipation?	☐	☐
24. Have problems with sleepwalking?	☐	☐
25. If female, have an abnormal menstrual history?	☐	☐
26. Have a history of bed-wetting?	☐	☐
27. Ever had an eating disorder?	☐	☐
28. Ever had emotional difficulties for which professional help was sought?	☐	☐

Please explain any "yes" answers, noting the number of the questions.

_____

_____

_____

_____

_____

Which of the following has the participant had?

- ☐ Measles
- ☐ Chicken pox
- ☐ German measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ **HepatitisB**
- ☐ **Hepatitis C**

TB Mantoux Test
Date of last test _____
Result: ☐ Positive ☐ Negative

Please give all dates of immunization for:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	
MMR	_____	_____				
or Measles	_____	_____				
or Mumps	_____	_____				
or Rubella	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Varicella (chicken pox)	_____	_____				

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

_____

_____

_____

_____

_____

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. (ACA accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions

_____

_____

_____

_____

Recommendations and Restrictions at Camp

Treatment to be continued at camp

_____

_____

Medications to be administered at camp (name, dosage, frequency)

_____

_____

Any medically-prescribed meal plan or dietary restrictions

_____

_____

Known allergies

_____

_____

Description of any limitation or restriction on camp activities

_____

_____

Additional information for health care staff at the camp

_____

_____

Signature of Licensed Medical Personnel _____

Printed_____ Title _____

Address _____

Phone _____ Date _____

For camp use only

Screening Record

Date screened_____ Time_____ am pm

Meds received _____

_____

Updates/additions to health history noted ☐ Yes ☐ No ☐ None required

Current health needs identified _____

_____

Observational notes_____

_____

Screened by _____