Wendell P. Clark Memorial YMCA
155 Central Street ~ Winchendon, MA 01475
978-297-YMCA (9622) Fax: 978-297-0958
www.clarkymca.org

YMCA USE ONLY: Documentation	
	This form filled out & signed
	Payment in Full / Deposit
	Physical Form received
Mem Type:	Mem Exp:

CAMP CLARK REGISTRATION FORM

Only One (1) Camper Per Registration Form

CAMPER INFORMATION: ***Did your child attend Camp Clark Last Year? Yes_____No_____**

First Name:_____ Last Name: _____ Phone:_____

Address: _____ City:_____

State:_____ Zip:_____ Age:_____ Date of Birth:_____ Gender: _____

Grade Entering Aug. 2019*_____ Shirt Size: Youth / Adult: S M L XL

PARENT/GUARDIAN INFORMATION:

1. Name:_____
   Address:_____
   City:_____
   State:_____ Zip:_____
   Home Phone:_____
   Cell Phone:_____
   Work Phone:_____
   E-Mail:_____

2. Name:_____
   Address:_____
   City:_____
   State:_____ Zip:_____
   Home Phone:_____
   Cell Phone:_____
   Work Phone:_____
   E-Mail:_____

Please enter price for each Day Camp, Pre-Camp and/or Post-Camp Care that your child will be attending.
Pricing Per Session: Day Camp: $70 Members/$95 Non-Members ~ Pre-Camp $10 ~ Post-Camp $10
Camp Explorers*: $85 Members/$110 Non-Members ~ Pre-Camp $10 ~ Post-Camp $10
CIT Program: $140 Members/$190 Non-Members
Specialty Camp: Specialty Camp/Day Camp $90 Members/ $115 Non-Members
Only Specialty Camp $65 Members/$90 Non-Members
****A non-refundable, non-transferable 50% deposit per camper PER SESSION is required at the time of registration to hold a spot.**
The remaining balance of each session is due no later than 3 weeks prior to that session's start date.**

Session	Day Camp (9am-4pm) age 6-12	Camp Explorers* (9am-4pm) age 4-6	Pre-Camp (7-9am)	Post-Camp (4-5:30pm)	CIT (9am-4pm)	Specialty Camp (AM)	Specialty Camp (PM)	TOTAL
Session 1: June 24-28	$	$	$	$		$		
Session 2: July 1-5	$	$	$	$		$		
Session 3: July 8-12	$	$	$	$		$		
Session 4: July 15-19	$	$	$	$		$		
Session 5: July 22-26	$	$	$	$				
Session 6: July 29-Aug. 2	$	$	$	$		$		
Session 7: Aug.5-9	$	$	$	$		$		
Session 8: Aug. 12-16	$	$	$	$		$		
Session 9: Aug. 19-23	$	$	$	$				
Grand Total Camp Clark								$

Children entering first grade and below in the fall of 2019 will be enrolled in the Camp Explorers Program

MEDICAL & ALLERGY INFORMATION:

Chronic health conditions: _____

Allergies: _____

Special limitations or concerns: _____

PICK-UP AND DROP-OFF INFORMATION:

My child may walk home after camp each day (initial): _____ *YES* _____ *NO*

Your child must be signed in and out every time they are dropped off at or picked up from the Clark Memorial YMCA. **Only parents/guardians and the individuals listed below are authorized to pick up or drop off a child.** Children will not be released to individuals without a photo I.D. at pick-up. Signing parent/guardian understands these terms and agrees to abide by them.

AUTHORIZED PICK-UP

1st non-parent/guardian contact name: _____

Relation to child: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

2nd non-parent/guardian contact name: _____

Relation to child: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

3rd non-parent/guardian contact name: _____

Relation to child: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

4th non-parent/guardian contact name: _____

Relation to child: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

You may include additional authorized pick-ups on the back of this sheet. Be sure to minimally include their name, address, and a phone number.

Parent Signature:_____ Date:_____

Clark Memorial YMCA

Camp Clark Payment Agreement

Adult Name:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____

Children in Camp:_____

E-Mail Address: Total Payment: $_____

Please calculate your total camp payment (# of Session fees attending + fees for each Pre and Post Care PER CHILD) and enter it in the space above. A non-refundable, non-transferable 50% deposit per camper PER SESSION is required at the time of registration to hold a spot. The remaining balance of each session is due no later than 3 weeks prior to that session's start date.

You may either attach a check for the applicable amount to this form OR fill out your credit card information below.

Once payment is processed the Clark Memorial YMCA will notify you to confirm your child(ren)'s registration.

PERSONAL CHECK	CREDIT CARD – circle one option:
I am attaching a check for the below total amount:	VISA MC AMEX DISCOVER
Check Amount:$_____	Amount to be charged: _____
Check #:_____	Name on Card:_____
Bank Name:_____	Card #:_____
	Exp. Date:_____

* I authorize the Clark Memorial YMCA to process my enclosed personal check, MasterCard, Visa, American Express or Discover Card for my Camp Clark fees payment. If for any reason my payment is not honored by my bank/credit card company, I understand that I am still responsible for the full total amount and any returned fees that may occur.

Clark Memorial YMCA – EFT Payment Agreement

Two or more returned payments may result in dismissal from the program. I realize that I am still responsible for payment, in addition to any and all returned fees or insufficient funds fees assessed by the Clark Memorial YMCA.

I have read and understand the above terms and conditions of this agreement:

_____ _____

Signature Date

PHYSICAL AND IMMUNIZATION

<u>**All campers MUST have current physical forms and immunization forms submitted to camp 3 weeks prior to attending**</u>! Campers will be <u>**turned away**</u> if forms are not in!

The attached Massachusetts School Health Record Sheet may be filled out by your child's physician and turned in to us. A complete Immunization Record must be attached to the form.

I, (parent/guardian name)_____ understand that my child will not be permitted to attend camp if I do not submit current physical and immunization forms to the Clark YMCA 3 weeks prior to their start date at camp.

ASSUMPTION OF RISK & RELEASE: Camper Name:_____ In consideration of being permitted to participate in Day Camp and/or Sports Camp, I the undersigned, and in full recognition and appreciation of the dangers and hazards inherent in such activities, including but not limited to athletics, outdoor activities and field/bus trips. I do for myself, my heirs and personal representatives hereby defend, hold harmless, indemnify, release and forever discharge Wendell P. Clark Memorial YMCA and all it's officers, agents and employees from and against any and all claims, demands and actions, or causes of actions, on account of damage to personal property and/or personal injury or death, which may result from participation, and which result from causes beyond the control of, and without the fault or negligence of Wendell P. Clark Memorial YMCA, it's officers, agents or employees during the period of participation.

<u>**PHOTO/VIDEO RELEASE:**</u> (Please **initial** the appropriate line)

_____ <u>**I give permission**</u> for the YMCA to use my child's photo for program and promotional materials for the YMCA and any media releases.

_____ <u>**I DO NOT give permission**</u> for the YMCA to use my child's photo for program and promotional materials for the YMCA and any media releases.

<u>**FIELD TRIP:**</u> (Please **initial** the appropriate line)

_____ <u>**I give permission**</u> for my child to attend off-site field trips included with camp. I understand I will have to sign the appropriate form on Monday of each week of camp during check-in.

_____ If you **decline**, please provide a written note each Monday stating that your child will not be attending that week's field trip. *Note: There <u>will not</u> be alternative care for children that do not participate in field trips.*

SIGNING PARENT UNDERSTANDS:

~ ***<u>A full, non-refundable payment is due at time of registration</u>***

~ Physical examination form, dated within 1 year of date of camp session, and immunization forms must be received by the Clark Memorial YMCA 3 weeks prior to child's attendance. Forms may be mailed, faxed or hand-delivered. If you fax or mail your forms, you are strongly advised to call and verify that they have been received. School physical forms are acceptable. If forms are not received on time, the child is subject to losing their spot and will not be allowed to attend camp.

~ It is the Parent's responsibility to bring any special concerns regarding their child to the attention of the Camp Director at the time of registration.

~ The Camp Director reserves the right to dismiss a camper when, in their judgment, the camper's behavior interferes with safe camp operation, the rights of others, the smooth functioning of activities or groups or violates the camp's principles of conduct.

~ This camp must comply with regulations of the Massachusetts Department of Public Health and be licensed by the local Board of Health.

~ Once a week there will be an off-site field trip. Parents will need to provide a written notice the Monday of each camp week if their child will not be participating. *There will NOT be alternative care for children not participating in field trips.*

I have read, understand, and agree to abide by all of the above.

Release executed by (Print Parent/Guardian Name):_____ to Wendell P. Clark Memorial YMCA, 155 Central Street, Winchendon, MA 01475.

Parent/Guardian Signature:_____ Date:_____

CLARK MEMORIAL YMCA DAY CAMP
EMERGENCY CARD INFORMATION

Child's Name:_____

Date of Birth:_____

Child's Home Address:_____

_____ Phone: _____

INSTRUCTIONS TO REACH PARENT/GUARDIAN

1._____
(Name, Address, Phone #)

2._____
(Name, Address, Phone #)

PEDIATRICIAN OR SOURCE OF HEALTH CARE

1. _____
(Doctor's Name, Address, Phone#)

EMERGENCY CONTACT PERSON(S)

1. _____
(Name, Address, Phone #)

2. _____
(Name, Address, Phone #)

MEDICAL EMERGENCY TREATMENT

I hereby give _____
(Name of program)
permission to administer basic first aid and/or CPR to my child _____
(Name)
and/or take my child _____, to a hospital for medical
(Name)
treatment when I cannot be reached or when delay would be dangerous to my child's health.

_____ _____

(Parent Signature) **(Date)**

INSURANCE INFORMATION (OPTIONAL)

Company Name:_____ Policy #_____

Participating Hospital:_____

Special Instructions:_____

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name _____ ☐ Male ☐ Female Date of Birth: _____

Medical History _____

_____

Pertinent Family History

Current Health Issues

Y **N**

☐ ☐ Allergies: Please list: Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi -Pen®: ☐ Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure disorder: _____

☐ ☐ Other (*Please specify*) _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:** _____

Hgt: _____(_____%) Wgt: _____(_____%) BMI: _____(_____%) BP: _____

(Check = Normal / If abnormal, please describe.)

☐ General _____ ☐ Lungs _____ ☐ Extremities _____

☐ Skin _____ ☐ Heart _____ ☐ Neurologic _____

☐ HEENT _____ ☐ Abdomen _____ ☐ Other _____

☐ Dental/Oral _____ ☐ Genitalia _____

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other _____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
TB Test Type: ☐ TST ☐ IGRA Date: _____ Result: ☐Positive ☐Negative ☐Indeterminate/Borderline
Referred for evaluation to: _____ Date: _____ ☐ Low risk (no TB test done)

This student has the following problems that may impact his/her educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations: _____

☐Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** _____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record** .

_____ _____

Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____

Group Practice Telephone

_____

Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 08/15/13*