

# School's Out Registration

## Camper Information

<b>Child's Name</b> _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Address</b> _____	<b>Birthdate:</b> _____
<b>City, State, Zip</b> _____	<b>Age:</b> _____
<b>Home Phone</b> _____	

## Parent/Guardian Information

### Mother or Legal Guardian Information

### Father or Legal Guardian Information

Last Name: _____	Last Name: _____
First Name: _____	First Name: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____
Employer: _____	Employer: _____
Email: _____	Email: _____

### Joint Custody Information

Has there been a divorce or separation?                       Yes     No

If Yes, who has custody? \_\_\_\_\_

The joint/non-custodial parent should be contacted in the event of an emergency                       Yes     No

## Emergency Contacts (Two contacts other than parent/guardian that campers may be released to if parents are unavailable)

### Emergency Contact #1

### Emergency Contact #2

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Cell Phone: _____	Cell Phone: _____

## Medical and Behavior Questions to help us provide the best care possible

### Copies of child(ren)s immunization record must be on file at camp office no later than May 1, 2011

<p><b>Has your child been diagnosed or treated for the following:</b></p> <p><input type="checkbox"/> Asthma                      <input type="checkbox"/> Allergies                      <input type="checkbox"/> Special Dietary Needs</p> <p><input type="checkbox"/> Allergies to Insect Stings                      <input type="checkbox"/> Seizures                      <input type="checkbox"/> Spectrum Disorder</p> <p><input type="checkbox"/> Allergy to Poison Ivy                      <input type="checkbox"/> ADD/ADHD                      <input type="checkbox"/> Other _____</p> <p><b>Please provide details for any of the above checked boxes:</b></p> <p>_____</p> <p>_____</p>	<p style="text-align: center; background-color: black; color: white; padding: 2px;"><b>Family Physician Information</b></p> <p>Physician's Name: _____</p> <p>Phone Number: _____</p> <p>Insurance Carrier: _____</p> <p>Policy Number: _____</p>
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## Registration Information

**Drop Off & Pick Up Location**     Mount Laurel     Riverfront

**Membership Level**                       Primetime PLUS                       Full/Program                       Non Member

**Dates Attending**                       9/29     10/10     11/7     11/8     11/9     11/10     11/11     12/26     12/27     12/28     12/29     12/30

1/16     2/17     4/9     4/10     4/11     4/12     4/13

**Total Amount Due:** \_\_\_\_\_

## Parent Statement of Understanding

My child is in good health and can participate in the normal activities of the program	_____ Initial Here
I understand that my child must be physically signed in and out of the program by authorized adults	_____ Initial Here
I understand that the YMCA is not responsible for lost, stolen or damaged personal articles	_____ Initial Here
<b>I give permission to the YMCA of Burlington and Camden Counties to:</b>	
Seek medical treatment for my child, in my absence, in the event of an emergency	_____ Initial Here
Use any photos, voice recordings or videos taken of my child for any and all promotional purposes	_____ Initial Here
To transport my child as necessary for all activities. This may include bussing for swimming and trips	_____ Initial Here
Allow my child to go on short walks under Y Staff Supervision	_____ Initial Here
<b>Parent/Guardian Signature:</b> _____	<b>Date:</b> _____