A GREAT PLACE TO GROW

Summer Camp
Enrollment Packet
June 19th – August 25th
Ages 5–8 @ YMCA Site
Ages 9–13 @ Lowell Catholic Site
PARENT CONTRACT

PLEASE TAKE A MOMENT TO READ THE FOLLOWING TERMS AND CONDITIONS

* I agree to pay a non-refundable registration fee of $35.00 (siblings $25.00).

* I agree to pay my first week's tuition in advance, at the time of registration.

* I agree that should I withdraw my child from the program, I will provide the YMCA with a 2 week written notice prior to the last day of my child’s attendance. I will pay an extra week of tuition past the last day of attendance if I do not provide this written notice.

* I agree to pay my share of the cost of the program as specified in the “Parent Fee Agreement” or Parent Fee Contract. I agree to remit each week's fee by the Friday prior to the week of attendance. I understand that there is a $10.00 late fee for payments made after that Friday.

* I understand that the YMCA will only accept payment by check, money order, or credit/debit cards.

* I agree and understand that drop-off time is between 7AM-9AM. Anyone coming in after 9AM will not be provided care.

* I agree to pick my child up by 6:00 PM or earlier. I understand that in the event my child is not collected by 6:00 PM, I will be responsible for a late fee of $1.00 per minute. If I have not picked up my child by 6:30 PM, my emergency contacts will be called. In the event that my emergency contacts cannot be reached, the Police Department will be called.

* I agree that I or someone authorized to pick up will personally sign my child out every day. I understand that is my responsibility to provide alternative arrangements for picking up my child if I am unavailable.

* I agree that the YMCA will be not be held accountable for any and all injuries occurring to my child, unless the injuries are a direct result from acts of negligence on the part of the YMCA.

* I agree that the YMCA is not responsible for any lost or stolen items that my child brings to camp.

* In the event of an emergency, I give permission to the YMCA staff to have my child treated by medical personnel. The staff member in charge shall make reasonable attempts to contact me prior to any emergency medical treatment.

* I understand that in the event of continued late payment of tuition, late pick up of my child or for any other good cause, the YMCA reserves the right to remove my child from the program.

_________________________________________  ____/____/_______
Signature of Parent/Guardian          Date
ENROLLMENT FORM

CIRCLE your Camp Site: Lowell YMCA–Ages 5–8  Lowell Catholic–Ages 9–13

(Please Print Clearly)

Camper’s Name: ___________________________ Birth Date: _____/_____/____ Gender: M  F
Address: ______________________________________
City: ___________________________ State: _______ Zip Code: __________________
Parent/Guardian: __________________________________________ Parent/Guardian: __________________________
Date of Birth of Parent: _____/_____/____ Date of Birth of Parent: _____/_____/____
Relationship to child: __________________________________________ Relationship to child: __________________________
Address (if different from child): __________________________ Address (if different from child): __________________________
Home Phone #: __________________________ Home Phone #: __________________________
Work Phone #: __________________________ Work Phone #: __________________________
Cell Phone #: __________________________ Cell Phone #: __________________________

(Please Print Clearly) Parent Email ____________________________ @________

If Parents/Guardians do not live together is there a custody agreement? YES____ NO____

Please explain and attach documentation:
________________________________________________________________________
________________________________________________________________________

Emergency Contact (other than Parent):

Phone #: __________________________ Relation: __________________________

Emergency Contact (other than Parent):

Phone #: __________________________ Relation: __________________________

Pick Up List (other than Parents, Emergency Contacts):

Name: __________________________ Phone #: __________________________
Name: __________________________ Phone #: __________________________
Name: __________________________ Phone #: __________________________

I agree that the information I have provided above is correct to the best of my knowledge.

_________________________ __________________________
Signature of Parent/Guardian Date

* SUNSCREEN: I give permission to the YMCA staff to apply sunscreen to my child as necessary.

_________________________ __________________________
Signature of Parent/Guardian Date

* PHOTO RELEASE: I give permission to the Greater Lowell YMCA Kids Club Camp or local newspaper media to photograph my child and to put the finished slides/photographs in local newspapers or presentations of YMCA programs to be used for public information and YMCA promotions.

_________________________ __________________________
Signature of Parent/Guardian Date
HEALTH FORM

* PLEASE PROVIDE US WITH A COPY OF YOUR CHILD’S IMMUNIZATION RECORD ONE WEEK PRIOR TO ATTENDANCE

Camper’s Name: _____________________________________________________________

Birth Date: __________/________/__________ Gender: M F

Address: ________________________________________________________________

City: __________________________________ State: __________ Zip Code: ____________

Parent/Guardian: _________________________________________________________

Home Phone #: ___________________________ Home Phone #: _______________________

Work Phone #: ___________________________ Work Phone #: _______________________

Please list current medications & fill out attached action plans if needed (Medications must be brought in with original packaging and label):

___________________________________________________________________________

Please provide us with a brief health history of your child (surgeries with dates, disabilities, chronic illnesses, disorders, dietary modifications, allergies, restrictions on any specific activity, etc.):

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Name of Physician: ___________________________ Phone #: _________________________

Insurance Company: _________________________ Policy #: __________________________

Please list any and all conditions that staff members need to be aware of to better interact with your child.

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities. I hereby authorize certified staff members to perform basic First Aid treatment for my child as necessary. Emergency Authorization: I hereby give permission to the medical personnel selected by the camp director to order X-Rays, routine tests and treatment for my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. I also give the camp director permission, in the event of an emergency, to authorize transportation for my child. This form may be photocopied for use out of camp.

________________________________________________________

Signature of Parent/Guardian

__/____/____

Date
PARENT FEE AGREEMENT FORM

CIRCLE your Camp Site:  Lowell YMCA-Ages 5-8  Lowell Catholic-Ages 9-13

Camper’s Name: ___________________________ Birth Date: _____/_____/______ Gender: M    F

Address: ________________________________________________________________

City: ___________________________ State: _______ Zip Code: __________________

Please check the box next to the weeks you wish for your child to attend.

Cost = $180.00/week

☐ Week #1: June 19 - 23  ☐ Week #6: July 24 - 28
☐ Week #2: June 26 - 30  ☐ Week #7: July 31 – August 4
☐ Week #3: July 3 – 7 CLOSED JULY 4th  ☐ Week #8: August 7 - 11
☐ Week #4: July 10 - 14  ☐ Week #9: August 14 - 18
☐ Week #5: July 17 - 21  ☐ Week #10: August 21 - 25

REGISTRATION FEE is $35.00-first child, $25.00-siblings: $ ____________________
DEPOSIT FEE is #weeks _____ X $20.00: $ __________________
TOTAL DUE at time of Registration is: $ __________________

Check all that apply and complete:

☐ I have a Full Time or Part Time Voucher through Child Care Circuit – Circle Voucher
   Parents must ask the YMCA Billing Dept. for an “Intake Form” to bring to your Voucher Appointment.
   Give the YMCA a copy of your Voucher and the first week’s tuition before your child’s first day! Weekly tuition is specified on the CCC contract.

☐ My child care will be ___fully or ___Partially subsidized by a 3rd Party (other than YMCA)
   Name of Organization: _______________________________________________________
   Address: ___________________________ City: __________________ State: __________
   Contact Name: ____________________ Phone#: __________________

☐ I am applying for Financial Assistance through the YMCA
   Financial Aid Application must be completed and approved before the child’s first day

\* REGISTRATION FEE: $35.00 per child, $25.00 for sibling (NON-REFUNDABLE)
\* DEPOSIT FEE: $20.00 per week (NON-REFUNDABLE)
\* Weekly Tuition: $180.00, regardless of attendance
\* Late Pick-up Fee: $1.00 per minute after 6:00 PM – repeat offenders will be terminated
\* Voucher recipients: follow rates as specified on individual Voucher
\* Additional charges may apply for special events: field trips, parties, etc.

**I agree to pay the tuition and fees as specified above for my child’s care each week. I understand that it is the YMCA policy to collect tuition one week prior to attendance. I agree to pay a late fee of $10.00 whenever my account is not paid in full. I understand the YMCA reserves the right to increase the above rates and fees at any time. Should this be necessary, the YMCA is obliged to give a 2 week notice to participants before the implementation of any increase. I agree to pay such changes in fees and tuition ad required.

_________________________________________________________   __________/_________/__________
Signature of Parent/Guardian                   Date
**Individual Health Care Plan Form**  
Plan must be renewed annually or when child’s condition changes

*Check all that apply...*

<table>
<thead>
<tr>
<th>Plan was created by:</th>
<th>Plan is maintained by:</th>
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</thead>
<tbody>
<tr>
<td>— Parent</td>
<td>Director</td>
</tr>
<tr>
<td>— Doctor or Licensed Practitioner</td>
<td>Assistant Director</td>
</tr>
<tr>
<td>— Program’s Health Care Consultant</td>
<td>Child’s Educator</td>
</tr>
<tr>
<td>— Older school age child (9+ yrs. of age)</td>
<td>Other: __________________</td>
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</tbody>
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<thead>
<tr>
<th>Name of child:</th>
<th>Date:</th>
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<tr>
<th>Any change to the child’s Health Care Plan?</th>
<th>NO (updated physician/parental signatures required)</th>
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<tbody>
<tr>
<td>YES (indicate changes below)</td>
<td></td>
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<table>
<thead>
<tr>
<th>Name of chronic health care condition:</th>
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<table>
<thead>
<tr>
<th>Description of chronic health care condition:</th>
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<tr>
<th>Symptoms:</th>
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<tr>
<th>Medical treatment necessary while at the program:</th>
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<tr>
<th>Potential side effects of treatment:</th>
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<tr>
<th>Potential consequences if treatment is not administered:</th>
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<tr>
<th>Name of educators that received training addressing the medical condition:</th>
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<tr>
<th>Person who trained the educator (child’s Health Care Practitioner, child’s parent, program’s Health Care Consultant):</th>
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<tr>
<th>Name of Licensed Health Care Practitioner (please print):</th>
<th>Date:</th>
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<tr>
<th>Licensed Health Care Practitioner authorization:</th>
<th>Date:</th>
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<tr>
<th>Parental/Guardian consent:</th>
<th>Date:</th>
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### For Older Children ONLY (9+ years of age)

With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child’s Individual Health Care Plan specifying how the inhaler or epinephrine autoInjector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

<table>
<thead>
<tr>
<th>Age of child:</th>
<th>Date of birth:</th>
<th>Back-up medication received?</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>YES</td>
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<tr>
<th>Parent signature:</th>
<th>Date:</th>
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<table>
<thead>
<tr>
<th>Administrator’s signature:</th>
<th>Date:</th>
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</table>
Name of child: ______________________________________________________________

Name of medication: _________________________________________________________

Please ☑ one of the following:     Prescription: _____      Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms______

Topical Non-Prescription (applied to open wound/ broken skin)______

My child has previously taken this medication____

My child has not previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan______

Dosage: ___________________________________________________________________

Date(s) medication to be given: _________________________________________________

Times medication to be given: __________________________________________________

Reasons for medication: _______________________________________________________

Possible side effects: _________________________________________________________

Directions for storage: ________________________________________________________

Name and phone number of the prescribing health care practitioner: 
_________________________________________________________________________

Child's Health Care Practitioner Signature ___________________ Date ________________

I, __________________________________________, (parent or guardian) gives permission 
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature ________________ Date ________________

For topical, non-prescription NOT applied to open wound / broken skin (parent signature only)