

# Boys & Girls Clubs of Albany Camp Enrollment Form

## Camp Thacher Opportunities

**Ages:**

6 – 13 years old

**Session Dates:**

I: July 6, 2009 – July 17, 2009 (application deadline 7/1/09)

II: July 20, 2009 – July 31, 2009 (application deadline 7/14/09)

III: August 3, 2009 – August 14, 2009 (application deadline 7/28/09)

**Days/Hours of Operation:**

Monday – Friday

8:30 a.m. – 4:30 p.m.

Please choose **ONE** two-week session. Check the session in the appropriate box with regard to your chosen bus stop. If you live at the Ida Yarbrough site, your child may attend **ALL THREE** sessions.

<b>Session</b> →	<b>7/6-7/17/09</b>	<b>7/20-7/31/09</b>	<b>8/3-8/14/09</b>
<b>Bus Stop</b> ↓			
<i>Delaware Avenue</i>			
<i>Philip Schuyler North Lake Avenue</i>			
<i>Ezra Prentice Club South Pearl Street</i>			
<i>Creighton Storey Club Third Avenue</i>			
<i>Ida Yarbrough Club North Pearl Street</i>			

Please return application to:  
 Boys & Girls Clubs of Albany  
 21 Delaware Avenue  
 Albany, New York 12210  
 518.462.5528

# Boys & Girls Clubs of Albany Camp Enrollment Form-CO

## Child Information

Child's Name: \_\_\_\_\_ Sex: M F  
Date of Birth: \_\_\_/\_\_\_/\_\_\_ School: \_\_\_\_\_ Grade Entering: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_

## Parent/Guardian Information

Parent/Guardian Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell: \_\_\_\_\_ Pager: \_\_\_\_\_ Email: \_\_\_\_\_  
2<sup>nd</sup> Parent/Guardian Name: \_\_\_\_\_  
**Parent's Marital Status:** (Married, \*Divorced, Single, Widowed) \_\_\_\_\_  
If separated or divorced, who has legal custody? \_\_\_\_\_  
*\* court order is needed if parent is denied access to a child*

## Pick Up Authorization

*I authorize the following people to pick up my child from the Club's Camp Program.  
All authorized persons MUST BE AT LEAST 16 years of age and be prepared to show PHOTO ID.*

Name	Relationship	Phone No.
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

**My child has permission to walk home from the bus stop. Please be specific w/dates and times.**

\_\_\_\_\_  
Parent/Guardian Signature

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## Medical Information

### Allergies & Special Needs

Does your child have any Allergies? Y or N

Please list: \_\_\_\_\_

Does your child take any Medication? Y or N

Please list: \_\_\_\_\_

Does your child have any special needs?

Please describe: \_\_\_\_\_

### Physician Information

Physician name: \_\_\_\_\_ Office name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Please indicate if the camper has a history of the following:**

contact lenses

fainting

appendicitis

anemia

diabetes

hay fever

swimmer's ear

high blood pressure

skin problems

hyperkinesias

severe headache

tonsillitis

asthma

ear infections

seizures

other: \_\_\_\_\_

Please Note: Immunization and physical records MUST be included with enrollment packet in order to register for Camp!!

## Emergency Information

**I being the parent/legal guardian of the above named minor do hereby appoint the B&GCA staff to act on my behalf in authorizing emergency medical, dental or surgical care and hospitalization in my absence for above named minor.**

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Emergency Contacts (if parents cannot be reached)

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone

# Boys & Girls Clubs of Albany Camp Enrollment Form-CO

Child's Name \_\_\_\_\_

## Conditions of Acceptance

1. I agree to return all Camp enrollment forms to the Boys & Girls Clubs of Albany prior to my child(ren) starting Camp. ***Children may not participate in Camp until all forms are completed and on file with the Club.***
2. I understand that any changes to my original registration must be submitted in writing.
3. I understand that my child must comply with Camp rules and standards of behavior. I agree that the Club's Camp Staff has the right to enforce appropriate standards of conduct and may dismiss a Camper who infringes on the rights of others.
4. I give my permission for the use of any photographs, slides or videotapes, which may contain my child, to be used in the Boys & Girls Clubs of Albany promotional materials.
5. I give my permission for my child to be transported on a school bus and/or the Club van to and from Camp field trips and activities.
6. I certify that my child is capable of participating in Camp activities.
7. I grant the Boys & Girls Clubs and it's agents full authority to take whatever action they deem necessary regarding my child's health and safety and I fully release the Boys & Girls Clubs of Albany and it's agents from any liability in connection with those decisions.

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**DAY CARE REGISTRATION**

**PHOTO OF CHILD  
(Optional)**

Child's Full Name: \_\_\_\_\_

Does your child have any allergies?  Yes  No  
If Yes, what is your child allergic to? \_\_\_\_\_

Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.

Child's Source of Medical Care/Primary Care Physician's Name:	Telephone Number:
Child's Source of Dental Care/Dentist's Name:	Telephone Number:
Name Of Medical Care Facility/Hospital:	Telephone Number:

Would you like information on Child Health Plus?  Yes  No

EMERGENCY DATA	RELATIONSHIP	CONTACT NAME	TELEPHONE NUMBER DURING CHILD CARE	OTHER TELEPHONE NUMBER (Check type)
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other

CHILD'S FULL NAME:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female
CHILD'S HOME ADDRESS:	DATE OF BIRTH:
	HOME TELEPHONE NUMBER:
DATE OF ACCEPTANCE:	DATE OF DISCHARGE:
NAME OF PERSON APPLYING FOR CHILD:	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative <input type="checkbox"/> Other _____
	HOME TELEPHONE NUMBER:
	DAYTIME TELEPHONE NUMBER:
ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S):	
<p><b>AGREEMENTS</b></p> <p>I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.</p> <p>I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>In case of accident or injury, I authorize any and all emergency medical, dental, and /or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>I have provided information on my child's special needs (Allergies, Diet, Disabilities, and /or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>I agree to review and update this information whenever a change occurs and at least once every six months. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
SIGNATURE - PARENT OR PERSON(S) LEGALLY RESPONSIBLE	DATE:

Provider/Day Care Facility Name and Address:

**COMPLETE ONLY ONE APPLICATION FOR YOUR HOUSEHOLD**

F R D  
School Year 2006-2007  
Date Withdrew \_\_\_\_\_

**FAMILY APPLICATION FOR FREE AND REDUCED PRICE SCHOOL MEALS/MILK**

To apply for free and reduced price meals for your children, read the instructions on the back, complete only one form per household, sign your name and return it to \_\_\_\_\_ Call \_\_\_\_\_ if you need help. For additional names, list on a sheet of paper.

**1. CHILDREN IN SCHOOL:** (Complete a separate application for each foster child.)

Children's Names (Last, First, MI)	Grade/Teacher	School

**2. FOSTER CHILD:** If the above named child is the legal responsibility of a welfare agency or court, check this box.   
List the child's personal use income: \_\_\_\_\_ (Write "0" if the child has no personal use income.) Skip to Part 5.

**3. HOUSEHOLDS GETTING FOOD STAMPS OR TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF):** Complete this section and sign the application in Part 5 **OR** submit a Direct Certification letter from the Office of Temporary and Disability Assistance or Food Distribution Program on Indian Reservations (FDPIR). Complete a separate application for children with a different case number or no case number. Write your case number as provided on your benefit letter, **not the number on your benefit card.**

Food Stamp Case #: \_\_\_\_\_ TANF/FDPIR Case #: \_\_\_\_\_

**4. HOUSEHOLD MEMBERS & TOTAL HOUSEHOLD INCOME:** If you did not give a food stamp or TANF case number, or submit a Direct Certification letter, complete this part and all of part 5.

Show how often each amount is received. See Examples →	CURRENT INCOME/PAY PERIOD			
	Examples: \$100/weekly, \$100/bi-weekly, \$100/2x per month, \$100/monthly If pay period is not noted, the reviewing official will process the reported income amount as received WEEKLY.			
List the names of everyone in your household	Earnings From Work Before deductions	Child Support, Alimony, Etc.	Payments from Pension or Retirement	Other Income
	Amount / How Often	Amount / How Often	Amount / How Often	Amount / How Often
1. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
6. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
7. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

**5. SIGNATURE: An adult household member MUST sign the application before it can be approved.**

I certify that all of the information is true and that all income is reported. I understand that the information is being given for the school to receive federal funds; that school officials may verify the information and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and federal laws, and my children may lose meal benefits.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_ Mailing Address \_\_\_\_\_ Zip Code \_\_\_\_\_

**SOCIAL SECURITY NUMBER:** If Part 4 is completed, the adult who signs the application must provide his/her Social Security number.

**DO NOT WRITE BELOW THIS LINE - FOR SCHOOL USE ONLY**

**ANNUAL INCOME CONVERSION (ONLY CONVERT WHEN MULTIPLE FREQUENCIES ARE REPORTED ON APPLICATIONS):**  
WEEKLY X 52; EVERY 2 WEEKS X 26; TWICE A MONTH X 24; MONTHLY X 12

FOOD STAMP, TANF, Foster Child  
 INCOME HOUSEHOLD: Total Household Income/Frequency: \_\_\_\_\_ / \_\_\_\_\_ Household Size: \_\_\_\_\_

Application APPROVED for:  Free Meals  Reduced Price Meals  
 Temporary Free (expires in 45 days) \_\_\_/\_\_\_/\_\_\_  Application DENIED

Date Notice Sent: \_\_\_\_\_ Signature of Reviewing Official: \_\_\_\_\_ Date: \_\_\_\_\_

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**DAY CARE REGISTRATION**

**PHOTO OF CHILD  
(Optional)**

Child's Full Name: \_\_\_\_\_

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Name Of Medical Care Facility/Hospital:	Telephone Number:

Would you like information on Child Health Plus?  Yes  No

EMERGENCY DATA	RELATIONSHIP	CONTACT NAME	TELEPHONE NUMBER DURING CHILD CARE	OTHER TELEPHONE NUMBER (Check type)
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				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other

CHILD'S FULL NAME:		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female
CHILD'S HOME ADDRESS:		DATE OF BIRTH:
		HOME TELEPHONE NUMBER:
DATE OF ACCEPTANCE:	DATE OF DISCHARGE:	
NAME OF PERSON APPLYING FOR CHILD:	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian	HOME TELEPHONE NUMBER:
	<input type="checkbox"/> Caretaker <input type="checkbox"/> Relative <input type="checkbox"/> Other _____	DAYTIME TELEPHONE NUMBER:
ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S):		

**AGREEMENTS**

I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.

I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision.  Yes  No

In case of accident or injury, I authorize any and all emergency medical, dental, and /or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child.  Yes  No

I have provided information on my child's special needs (Allergies, Diet, Disabilities, and /or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency.  Yes  No

I agree to review and update this information whenever a change occurs and at least once every six months.  Yes  No

SIGNATURE - PARENT OR PERSON(S) LEGALLY RESPONSIBLE	DATE:
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Provider/Day Care Facility Name and Address: