Boys & Girls Clubs of Albany Camp Enrollment Form
Project Love

Ages:

4 -13 years old

Dates:

June 29, 2009 – August 21, 2009

Days/Hours of Operation:

Monday – Friday
8:00 a.m. – 5:00 p.m.

Please remember your child needs a current physical and all immunization records with the completed application.

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

Boys & Girls Clubs of Albany Camp Enrollment Form-PL

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: ____________

2nd 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. ______________________

Please Note: Any additions to the pick up list must be in writing.

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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

Boys & Girls Clubs of Albany Camp Enrollment Form-PL

Child's Name ______________________________

Conditions of Acceptance

1. I understand that my two week deposit will go toward my first two weeks of camp is **NON-REFUNDABLE**. Camper slots will not be reserved without a completed application and deposit.

2. I agree the balance due for each week of Camp is to be PAID **IN FULL BY the Friday prior to each week** of Camp that my child is enrolled or I will forfeit my spot for the rest of the summer. ***No child will be allowed to attend Camp until fees are paid up to date, nor will they be able to register for After School Programs.***

3. 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.***

4. I understand that any changes to my original registration must be submitted in writing.

5. I understand that the hours of operation are Monday through Friday from 8:00 a.m. until 5:00 p.m. Children are to be picked up by 5:00 p.m. Parents will be charged a late fee of $2 per minute starting at 5:15 p.m.

6. 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, ***without a refund***, a Camper who infringes on the rights of others.

7. I understand there is **NO REFUND** of any fees for voluntary permanent or temporary withdrawal or dismissal from Camp including any absences, illnesses or vacations.

8. 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.

9. 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.

10. I certify that my child is capable of participating in Camp activities.

11. 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)
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other

Provider/Day Care Facility Name and Address:

CHILD'S FULL NAME:	SEX: ☐ Male ☐ Female
CHILD'S HOME ADDRESS:	DATE OF BIRTH:
	HOME TELEPHONE NUMBER:
DATE OF ACCEPTANCE:	DATE OF DISCHARGE:

NAME OF PERSON APPLYING FOR CHILD:	☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ☐ Other ____	HOME TELEPHONE NUMBER:
		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:

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: ____________