

2017 Geneva Family YMCA Camp Registration and Health Form

Middle School Camp Voyager (Grades 6 – 8) _____

Please complete one registration form for each child. Please note that no application will be processed without the registration fee and a completed health form.

Camper Name: _____ Gender: M F

Date of Birth: _____ Age: _____ Grade Entering: _____ Member: Yes No

Address: _____

Home Phone: _____ E-Mail: _____

Mother/Guardian Full Name: _____ Work Place: _____

Work Phone: _____ Cell Phone: _____

Father/Guardian Full Name: _____ Work Place: _____

Work Phone: _____ Cell Phone: _____

EMERGENCY CONTACTS (other than parent/guardian):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Person Authorized to pickup child (other than parent/guardian)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

HEALTH INFORMATION (required at time of registration)

IMMUNIZATION HISTORY (required by New York State Department of Health)

Please provide an up to date record of all immunizations that your child has received.

This must be signed by your child's physician. **Most pediatric offices will fax the form directly to the Geneva YMCA. Our fax number is 789-4259. Thank you.**

Please indicate month and year for all dates:

_____ DPT Series _____ Booster

_____ Tetanus Booster _____ Polio DPV (Sabin) _____ Booster

_____ HIB

_____ Measles Vaccine _____ Live: _____ Tine

_____ Rubella (German measles)

_____ Mumps Vaccine (Live)

Health History –

___ Hay Fever _____ Learning problems

___ Ear Infections _____ Penicillin

___ Asthma _____ Diabetes

___ Special Diet _____ Behavior problems

___ Poison Ivy _____ Medication

___ Rheumatic Fever _____ Chicken Pox

___ Mumps _____ Convulsions

___ Insect Stings _____ Hearing

___ Vision _____ Food Allergies

Health Information (Cont'd)

Doctor's Name: _____

Doctor's Phone: _____ Insurance Carrier: _____ Policy Holder Name: _____

Policy #: _____ Date of last physical exam (Must be within 24 months of start of camp) _____

Recent Surgery (type and date): _____ Restrictions: _____

Any restrictions for any other reason: _____

Are there any medical or development conditions requiring attention? _____

Serious Injury (type and date): _____ Chronic or recurring illness: _____

Other conditions or details of above: _____

Have any significant events occurred in your family within the last few years? _____

Has your child been in therapy in the last two years? _____

Does your child take medication daily? Yes _____ No _____ Please give the name of medication /dosage/frequency: _____

Does your child have any serious fears? If so please explain: _____

Are there any problems that might confront your child at camp? (Homesick, anxiety, moodiness, etc) _____

Does your child wear/require a flotation device while in the pool? Yes _____ No _____

Does your child feel comfortable in deep water while swimming? Yes _____ No _____

The YMCA is required to report membership and program participation information to the United Way and various government agencies in support of annual allocation, grant, and community service requests. This information is not reported on an individual basis and is used for statistical purposes only. Please check the correct answer for both A and B:

A. Racial Status: ___Caucasian ___African American ___Asian ___Hispanic ___Native American ___Other

B. Annual Household Income: ___Less than \$5,000 ___\$5,000 - &9,999 ___\$10,000 - \$14,000
 ___ \$15,000-\$24,999 ___\$25,000 - \$34,000 ___Over \$35,000

INDICATE YOUR SESSION/DAY CHOICES

_____ Week 1	Friday July 14	Strawberry Fields Hydroponic Farm & Fillmore Glen State Park
_____ Week 2	Friday July 21	Cayuga Nature Center & Taughannock State Park
_____ Week 3	Friday July 28	Canoeing @ Fuzzy Guppies & Seneca State Park
_____ Week 4	Friday Aug. 4	Heaven Sent Blueberry Farm & Chimney Bluff State Park
_____ Week 5	Friday Aug. 11	Robert H Treman State Park
_____ Week 6	Friday Aug. 18	Bristol Mountain Areal Adventure & Kershaw Park

**Geneva Family YMCA
2017 Summer Day Camp
Waivers**

____ I understand that participants specifically assume all risk of injury arising out of his/her presence on the premises of the YMCA and its program premises. The participant's use of the YMCA's equipment or facilities and my participation in Y activities, whether on Y premises or another location, for myself and my heirs and assigns hereby waiver, release and agree to hold free from all claims for damages the YMCA and it's officers, directors, members, employees or agents. I understand the risks and dangers involved in participating in programs and activities of the YMCA.

____ The participant is physically capable of participating in such programs and agrees not to participate in any activity that may injure participants or others.

____ I hereby authorize the Geneva Family YMCA to provide transportation for my child via bus or by foot on various field trips, administer first aid (if needed) and transport to nearest hospital.

____ I hereby give permission to the Geneva Family YMCA Camp Staff to apply sunscreen to the participant as needed while they are in attendance at Camp.

____ I hereby authorize the Geneva Family YMCA Camp Staff to apply bug spray to the participant as needed while they are in attendance at Camp.

____ I hereby authorize the Geneva Family YMCA, to take photographs, videotape or digital recordings of the participant and to use these in any and all media. I further consent that the participants name and identity may be revealed therein or by descriptive text or commentary. I waive any rights, claims or interest I may have to control the use of the participants identity or likeness in whatever media used and understand that there will be no financial or other remuneration for recording me either for initial or subsequent transmission or playback.

____ In the event of an emergency, I authorize the Child Care Director/Preschool Teacher/Camp Director or his/her designee to act for me according to his/her best judgement in a situation requiring medical or surgical treatment and or transportation to a medical facility. I understand that I will be notified prior to any medical treatment of my child whenever possible. If prior notification of medical treatment is not possible, I will be contacted at the earliest possible time. I agree to be responsible for any medical bill resulting from illness or injury during my child's attendance in the above program.

Name of Participant (Please Print)

Parent/Guardian Signature (if under 18 years of age)