

# YMCA – CAMP SPINDRIFT

## 2009 Summary Registration Form

We meet or exceed all Summer Camp regulations as required by the Massachusetts Department of Public Health.

UPDATED: 051709RD

Child's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ Town: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_ YMCA Member? \_\_\_\_\_ Member #: \_\_\_\_\_

Please CIRCLE your choices		DAY CAMP	SMALL FRY	THEATRE ARTS	HORSE RIDING	C.I.T	MLS SOCCER	Extended Day <7:30AM >5:30PM
		(CIRCLE DAYS ATTENDING)	(CIRCLE DAYS ATTENDING)	Ages 11-14	Ages 7-14	Ages 14-16	HALF DAY FULL DAY	
6/15 – 6/19	PRE	M T W R F	M T W R F					ALL
6/22 – 6/26	1	M T W R F	M T W R F	CLOSED		ALL		ALL
6/29 – 7/3	2	M T W R F	M T W R F					ALL
7/6 – 7/10	3	M T W R F	M T W R F	CLOSED	ALL	ALL		ALL
7/13 – 7/17	4	M T W R F	M T W R F		ALL			ALL
7/20 – 7/24	5	M T W R F	M T W R F	CLOSED	ALL	ALL		ALL
7/27 – 7/31	6	M T W R F	M T W R F		ALL			ALL
8/3 – 8/7	7	M T W R F	M T W R F	CLOSED	ALL	ALL		ALL
8/10 – 8/14	8	M T W R F	M T W R F		ALL		ALL ALL	ALL
8/17 – 8/21	9	M T W R F	M T W R F	CLOSED	ALL	ALL		ALL
8/24 – 8/28	10	M T W R F	M T W R F		ALL			ALL
8/31 – 9/4	POST	M T W R F	M T W R F	CLOSED				ALL

\$40 deposit required to reserve a spot in each session

**TRANSPORTATION:    PARENT                    BUS (\$25/wk)                    XCARE (\$30/wk)**

**IN ACCORDANCE WITH MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH REGULATIONS: NO CHILD MAY ATTEND CAMP WITHOUT COMPLETED IMMUNIZATION/HEALTH HISTORY FORMS ON SITE. FAILURE TO SUBMIT THE ATTACHED FORMS WILL CAUSE CHILD TO BE EXCUSED FROM CAMP. NO REFUNDS WILL BE GIVEN.**

**TEXT BOX FOR YMCA / SPINDRIFT STAFF USE ONLY:**

DATE OF REG: \_\_\_\_\_ DEPOSIT TAKEN: \$ \_\_\_\_\_ RECEIPT NUMBER: \_\_\_\_\_ STAFF INITIALS: \_\_\_\_\_

NOTES: \_\_\_\_\_

**REQUIRED DOCUMENTATION IN FILE:**

**CAMP ADMINISTRATION NOTES:**

Immunizations \_\_\_\_\_  
 Transportation Choice \_\_\_\_\_  
 General Info Form \_\_\_\_\_  
 Physician's Medical Form \_\_\_\_\_

Allergies \_\_\_\_\_  
 Medications \_\_\_\_\_  
 Restrictions \_\_\_\_\_  
 Other \_\_\_\_\_



**2009 CAMP SPINDRIFT ENROLLMENT PACKET (1 of 5)**  
**REGISTRATION INFORMATION**

**CAPE ANN YMCA**  
 Tel 978.283.0470  
 Fax 978.283.3114

Camper Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_

Home Telephone \_\_\_\_\_ Family Email \_\_\_\_\_

**CUSTODIAL PARENT/GUARDIAN INFORMATION**

Parent/Guardian Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Home Address \_\_\_\_\_ if same as child, please write "same"

Home Address \_\_\_\_\_ if same as child, please write "same"

Home Phone Number \_\_\_\_\_ if same as child, please write "same"

Home Phone Number \_\_\_\_\_ if same as child, please write "same"

Business Name & Address \_\_\_\_\_

Business Name & Address \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Cell/Pager Number \_\_\_\_\_

Cell/Page Number \_\_\_\_\_

**TRANSPORTATION**

**My child will arrive at the program by:**

Parent/Guardian Drop Off

Unsupervised walk to the YMCA Camp Spindrift

Program Bus\* Stop \_\_\_\_\_

AM Extended Care Drop Off Time: \_\_\_\_\_

**My child will depart from the program by:**

Parent/Guardian Pick Up

Unsupervised walk from the YMCA Camp Spindrift

Program Bus\* Stop \_\_\_\_\_

PM Extended Care Pick Up Time: \_\_\_\_\_

I give permission for my child to be dropped off at his/her bus stop if an authorized adult is not present.

(If you do not authorize this, and an adult is not present, your child will be dropped off at the Cape Ann YMCA)

I give permission for my child to be released from the program at the end of the day as stated above and/or I give permission to the following people to receive my child at the end of the day.

(If no one is authorized, please indicate below by writing "no one.")

Name \_\_\_\_\_ Address \_\_\_\_\_ Relationship to child \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Relationship to child \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Any other transportation requests must be stated in writing and maintained in the child's file or the above plan must be implemented. This permission is valid for one program year from the date of signature.

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

\_\_\_\_\_  
 Date



**2009 CAMP SPINDRIFT ENROLLMENT PACKET (2 of 5)**  
**GENERAL INFORMATION**

**CAPE ANN YMCA**  
 Tel 978.283.0470  
 Fax 978.283.3114

Camper Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

**PEDIATRICIAN OR SOURCE OF HEALTH CARE**

\_\_\_\_\_  
 Doctor's Name Address Phone

\_\_\_\_\_  
 List Allergies/Special Diets/Chronic Health Conditions/Special Limitations...If there are no conditions, please write "none."

\_\_\_\_\_  
 Please list any medications currently being taken.

**MEDICAL EMERGENCY TREATMENT**

I hereby give the Cape Ann YMCA permission to administer basic first aid and/or CPR to my child and/or take my child to a hospital and to secure medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

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

**EMERGENCY CONTACT PERSON(S) – OTHER THAN PARENT(S)/GUARDIAN(S)**

\_\_\_\_\_  
 Name Address Phone

\_\_\_\_\_  
 Name Address Phone

**INSURANCE INFORMATION**

\_\_\_\_\_  
 Company Name Policy Number

\_\_\_\_\_  
 Participating Hospital Special Instructions

**OFF-SITE FIELD TRIP AUTHORIZATION (ONLY NEEDED IF ATTENDING SESSION 2 AND/OR 4)**

I give permission for my child to participate in the organized, scheduled and advertised field trips away from Camp Spindrift. These trips include, but are not limited to: Canobie Lake Park (Week 2), Water Country (Week 4).

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

**PARENT HANDBOOK RECEIPT**

I have received and reviewed the YMCA Camp Spindrift Parent Packet. I understand and agree to abide by the policies that have been established by the YMCA of the North Shore. These policies include:

- |                            |                     |                          |                    |
|----------------------------|---------------------|--------------------------|--------------------|
| Attendance Policy          | Late Pick-up Policy | Inclement Weather Policy | Health Care Policy |
| Medication/Administration  | Transportation      | Behavior Management      | Substance Abuse    |
| Termination and Suspension | Fee Payment         |                          |                    |

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



**2009 CAMP SPINDRIFT ENROLLMENT PACKET (3 of 5)**  
**PARENTAL INFORMATION SHEET**

**CAPE ANN YMCA**  
**Tel 978.283.0470**  
**Fax 978.283.3114**

Camper Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

We appreciate you placing your trust in us to care for your child this summer. We place the utmost importance upon each child's safety, well-being and overall camp experience.

Please help us by taking a few minutes to share your insights about your child. By doing so, please recognize any information provided on this sheet may be shared with members of the YMCA Camp Spindrift Staff Team.

**What should we know specifically about your child so we can provide the best of care?**

**What would you most like for your child to accomplish this summer at Camp Spindrift?**

**What would your child like to most accomplish this summer at Camp Spindrift?**





**2009 CAMP SPINDRIFT ENROLLMENT PACKET (5 of 5)**  
**PHYSICIAN'S MEDICAL FORM**

(Physician's own form may be used, providing all information is included)

CAPE ANN YMCA  
 Tel 978.283.0470  
 Fax 978.283.3114

Camper Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

**TO BE COMPLETED BY A PHYSICIAN:**

**Has the child/adolescent ever had:**

Frequent ear infections	Yes	No	Pneumonia	Yes	No
Bronchitis	Yes	No	Surgery	Yes	No
Kidney problems	Yes	No	Hospitalization	Yes	No
Heart problems	Yes	No	Broken bones	Yes	No
Convulsions	Yes	No	Chicken pox	Yes	No

If you answered "Yes" to any of the questions above, please explain:

Please list any medications the child takes on a regular basis: \_\_\_\_\_

Allergies \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Date of last physical \_\_\_\_\_ Ht \_\_\_\_\_ WT \_\_\_\_\_ HC \_\_\_\_\_ BP \_\_\_\_\_

Abnormal Findings \_\_\_\_\_ None \_\_\_\_\_ Finding \_\_\_\_\_

Hearing \_\_\_\_\_ Vision \_\_\_\_\_ Restrictions to normal activity Yes No

Comments \_\_\_\_\_

Special Notice, i.e. Medic Alert \_\_\_\_\_

**Immunizations & Dates:**

DPT DT Td	MMR	Last TB Date	Type _____
1.	1.	_____	Result _____
2.	2.	Last Lead Date	Result _____
3.		_____	
4.			
5.	HepB		
	1   2   3	Last Hgh/Hct Date	Result _____
Polio: Oral Inactive		_____	
1.			
2.	Hib		
3.	1   2		
4.	3   4		Result _____
5.			
	Flu _____	Varicella _____	

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

The Department of Public Health's Camping Regulations require that all campers and staff members be immunized against diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps, and rubella. This sheet must include the month, year, and type of immunization or occurrence of clinical disease. Exemptions are allowed for religious or medical reasons. Camp Director must ensure that each camper and staff member meets the Massachusetts immunization requirements before admittance to camp.