SUMMER CAMP REGISTRATION 2022

Camper Information: Child's First Name:_____ Last Name:_____
(One form per camper)

Address:_____ Phone Number:_____

Grade in Fall: _____ Date of Birth:_____ Gender: Male Female

Camper T-Shirt Size:_____ Membership type: _____

Parent/Guardian Name:_____ Phone:_____ Email:_____

Parent/Guardian Name:_____ Phone:_____ Email:_____

Address (If different from above):_____

REGISTER FOR CAMP WEEKS

Please only select 1 camp per week. Shaded areas are not available. Place an "x" for each camp in which you would like your child registered. Non-refundable deposits due at time of registraiton are $20/wk per child.

		WEEKS									
CAMPS	GRADES	1 6/20-6/24	2 6/27-7/1	3 7/5-7/8	4 7/11-7/15	5 7/18-7/22	6 7/25-7/29	7 8/1-8/5	8 8/8-8/12	9 8/15-8/19	10 8/22-8/26
K-Camp	K										
Traditional	1-6										
Leader's Club	7-9										
Sports	3-6										
Art	3-6										
Science & Nature	3-6										

FULL DAY CAMPS	family membership	youth membership	no membership
K-Camp, Traditional, Leader's Club	$140/wk	$150/wk	$180/wk
Sports, Art, Science & Nature	$150/wk	$160/wk	$190/wk

GRAND TRAVERSE BAY YMCA OFFICIAL REGISTRATION FORM, RELEASE AND WAIVER OF LIABILITY AND INDEMNITY AGREEMENT

IN CONSIDERATION of being permitted to utilize the facilities, services and programs of the YMCA (or for my children to so participate) for any purpose, including, but not limited to observation or use of facilities or equipment, or participation in any off-site program affiliated with the YMCA, the undersigned, for himself or herself and such participating children and any personal representatives, heirs, and next of kin, hereby acknowledges, agrees and represents that he or she has, or immediately upon entering or participating will, inspect and carefully consider such premises and facilities or the affiliated program. It is further warranted that such entry into the YMCA for observation or use of any facilities or equipment or participation in such affiliated program constitutes an acknowledgement that such premises and all facilities and equipment thereon and such affiliated program have been inspected and carefully considered and that the undersigned finds and accepts same as being safe and reasonably suited for the purpose of such observation, use or participation by the undersigned and such children.

In further consideration of being permitted to enter the YMCA for any purpose including, but not limited to observation or use of facilities or equipment, or participation in any off-site program affiliated with the YMCA, the undersigned hereby agrees to the following:

1. THE UNDERSIGNED ON HIS OR HER BEHALF AND BEHALF OF SUCH CHILDREN, HEREBY RELEASES, WAIVES, DISCHARGES AND CONVENANTS NOT TO SUE the YMCA and all branches thereof, its directors, officers, employees, and agents (hereinafter referred to as "releases") from all liability to the undersigned or such children and all his personal representatives, assigns, heirs, and next of kin for any loss or damage, and any claim or demands therefore on account of injury to the person or property or resulting in death of the undersigned or such children whether caused by the negligence of the releases or otherwise while the undersigned or such children is in, upon, or about the premises or any facilities or aequipment therein or participating in any program affiliated with the YMCA.
2. THE UNDERSIGNED HEREBY AGREES TO INDEMNIFY AND SAVE AND HOLD HARMLESS the releases and each of them from any, loss, liability, damage or cost they may incur due to the presence of the undersigned or such children in, upon, or about the YMCA premises or in any way ob serving or using any facilities or equipment of the YMCA or participating in any program affiliated with the YMCA whether caused by the negligence of the releases or otherwise.
3. 'I'HE UNDERSIGNED HEREBY ASSUMES FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH, OR PROPERTY DAMAGE to the undersigned or such children due to negligence of releases or otherwise while in, about or upon the premises of the YMCA and/or while using the premises or any facilities or equipment thereon or participating in any program affiliated with the YMCA.

The undersigned gives permission to the Grand Traverse Bay YMCA for this registrant to appear in photographs, videotapes, or other media, etc., associated with YMCA programs. PARENTS: Our staff is trained in child abuse prevention and all staff sign a code of conduct. Please report any suspicious activity immediately. The undersigned agrees to abide by the Program Refund Policy as stated in the YMCA quarterly Program Brochure. Refunds will be made in the form of program credits unless otherwise approved and requests for refunds must be made in writing prior to the program start date. Late fees are non-refundable.

The Grand Traverse Bay YMCA is founded on Christian principles and values and prohibits inappropriate behavior, conduct, and materials. This includes, but is not limited to, profanity or abusive language, attire, smoking, use of alcohol or drugs, weapons, fireworks, pornography, the removal or misuse of YMCA property, or criminal conduct of any type. Such inappropriate behavior, conduct, or materials is unacceptable and the YMCA consequently retains the right to deny memberships and program participation to its applicants and to revoke a membership of any current member or participant at its sole discretion. Pets are not allowed at YMCA facilities or off-site program locations. All program participants, guests, and members who are minors are not allowed to leave YMCA property unless accompanied by a relative or pre-authorized guardian. Some programs re-quire personal equipment not supplied by the YMCA. Further, the undersigned will at all times display the YMCA values of Honesty, Respect, Caring, and Responsibility and encourage the efforts of all players, coaches, spectators and referees in a positive manner. The undersigned understands the Y mission in offering this program: to build strong kids, strong families, and strong communities. YMCA PROGRAMS ARE NOT SPONSORED BY OR ASSOCIATED WITH T.C.A.P.S.

X Signature of Parent/Guardian: _____ Date: _____

PARTICIPATION WAIVER

As a parent, I understand as a part of the Grand Traverse Bay YMCA Summer Day Camp Program that my son/daughter participates involves light to moderate physical activity. Understanding that my Child will participate in physical activity on a daily basis, I acknowledge that my son/daughter is capable of meeting these physical requirements. I also affirm that my child is in good health and able to participate in YMCA Summer Day Camp Programs.

X Signature of Parent/Guardian: _____ Date: _____

FIELD TRIPS

I give my child permission to ride the Grand Traverse Bay YMCA Bus. I understand and release the bus to transfer my child to and from program field trips, in which the times and places of these trips is communicated to me. Please note that field trips are subject to change due to weather or any other reason.

X Signature of Parent/Guardian: _____ Date: _____

SUNSCREEN & BUG SPRAY

I give my permission to the Grand Traverse Bay YMCA to administer sunscreen and bug stray/repellant to my child as needed during Day Camps from June 20 - August 26, 2022. I will provide these items for my child's use.

X Signature of Parent/Guardian: _____ Date: _____

DAY CAMP GUIDE BOOK

I acknowledge that I have received a copy of the current copy of the YMCA Day Camp Parent's Handbook

X Signature of Parent/Guardian: _____ Date: _____

CANCELLATION POLICY

I acknowledge that I will be charged a $50 cancellation fee if I do not cancel my child's attendance 2 weeks in advance.

X Signature of Parent/Guardian: _____ Date: _____

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only: Date of Admission	Date of Discharge

Name of Child (Last, First, Middle Initial)				Child's Date of Birth
Address (Number and Street, Building/Apartment Number)		City	State	Zip Code
Father/Legal Guardian's Name	Home Phone ( )	Mother/Legal Guardian's Name		Home Phone ( )
Home Address (if not child's address)	Cell Phone ( )	Home Address (if not child's address)		Cell Phone ( )
City / State	Zip Code	City	State	Zip Code
Email Address (optional)		Email Address (optional)		
Employer Name	Work Phone ( )	Employer Name		Work Phone ( )
Name of Child's Physician or Health Clinic		Physician's or Health Clinic's Phone Number ( )		
Hospital Preferred for Emergency Treatment (optional)				
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)				

BCAL-3731 (Rev. 6-15) Previous edition 7-12 only may be used.

See Reverse Side

Emergency Contact & Release of Child: List all individuals,including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	( )	( )
2.	( )	( )
3.	( )	( )

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	( )	2.	( )
3.	( )	4.	( )

Parent/legal guardian must initial one of the following:

_____I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

_____I do not give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care. I understand I assume responsibility for all emerency medical care.

Signature of Parent or Guardian	Date Signed

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

LARA is an equal opportunity employer/program.
Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

BCAL-3731 (Rev. 6-15) Previous edition 7-12 only may be used.

HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. (**BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION**.)

PERSONAL

CHILD'S NAME (Last, First, Middle)	DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street) (City) (ZIP Code) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)	HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street) (City) (ZIP Code) MI	WORK TELEPHONE NUMBER ( )

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): _____
☐	☐		Does your child take any medication(s) regularly?

Reason for Medication

_____ / /

Parent/Guardian Signature Date

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications:

Was the health history reviewed by a health professional?

☐ Yes ☐ No ***Examiner's Initials:*** _____

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION	Visual Acuity			
			Muscle Imbalance			
		Date: / /	Other:			
☐	☐	HEARING	Audiometer			
			Other:			
		Date: / /				
☐	☐	URINALYSIS	Sugar			
			Albumin			
		Date: / /	Microscopic			
☐	☐	BLOOD LEAD LEVEL	Level _____ ug/dl ⇨			
		Date: / /				

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
		Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN	Type: _____			
		Date: / /	Neg.: ☐ Pos.: ☐ _____ mm			

NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.

Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /

SECTION III - IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	1	
	2	
	3	

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.

Parent/Guardian refused immunizations: ☐

I certify that the immunization dates are true to the best of my knowledge

Health Professional's Signature | Title | Date

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
☐	☐	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ (child's name)'s teeth. As a result of this examination, my recommendation for treatment is: _____

Dentist's Signature | Date

PHYSICIAN'S SIGNATURE

Examiner's Signature | Date | *Examiner's Name (Print or Type)* | Degree or License

Number & Street | City | MI | ZIP Code | ( ) Telephone

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

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Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

MEDICATION PERMISSION AND INSTRUCTIONS

CHILD CARE HOMES AND CENTERS

STATE OF MICHIGAN

Department of Human Services

Bureau of Children and Adult Licensing

If you are giving or applying any medication to a child in care, the following must be completed by the parent for **each** medication. An interruption in medication will require a new permission form.

TO BE COMPLETED BY PARENT

I give my permission for _____ to give or apply the medication
(Caregiver, Facility)

_____ , to my child _____ , as follows:
(Specify, prescribed medication/over the counter product) (Child's Name)

DIRECTIONS:

1. Date to Begin Giving Medication	2. Date to Stop Medication
3. Times Medication is to be Given	4. Amount (dosage) of Medication Each Time Given
5. Storage of Medication	
6. Other Directions, if Any	
Signature of Parent	Date

TO BE COMPLETED BY THE CAREGIVER GIVING THE MEDICATION:

DATE	TIME	AMOUNT GIVEN	CAREGIVER'S NAME	CAREGIVER'S SIGNATURE

It is recommended this form be reviewed with the parent every 3 months if the medication is ongoing.

TO BE COMPLETED BY THE CAREGIVER GIVING MEDICATION:

DATE	TIME	AMOUNT GIVEN	CAREGIVER'S NAME	CAREGIVER'S SIGNATURE