

INSTRUCTIONS FOR COMPLETION OF SUMMER CAMP PACKET

Registration Information:

This form will give us the details of your child's schedule as well as signed waivers necessary for your child's participation in our program. Please read all instructions at the top of the page and initial the box indicating that you have read them. Check the box(es) for each week for which you wish to register your child. Complete the lower portion of the form and sign the bottom of the form. At the time of registration, you will be asked to pay the registration fee and deposits for the summer. Colonial Sports staff will complete the payment information.

Emergency Contact/Parental Consent Form:

This is a mandated form. Every line must be completed. Ditto marks and "same as above" are not accepted. Please make sure the sections asking for addresses are filled out completely, including for the persons to whom the child may be released.

There must be **3 people listed for emergency contacts and 3 people to whom the child may be released**. The mother and father listed at the top of the form are assumed, but they may be listed again under the emergency contact and pick up persons if you do not have 3 other people to list outside of the parents for either section.

There are **6 signatures** required at the bottom of the form. The blocks with Emergency Medical Care and Minor First Aid are often missed.

Agreement:

This is a mandated form. Please complete the following:

Fill in Name of Child

Fill in Person(s) Designated by Parent to Whom Child May be Released

Check box regarding program information

Check box regarding emergency information

Sign and date

An administrator will complete the fee amount and per-day-week boxes with you.

Child Health Report:

A copy of your child's most current Health Assessment and Immunization Records is required within 30 days of enrollment. The form that comes back to us may look different than the one attached, but it needs to cover the same basic health information and full immunizations and be authorized and **signed** by a physician. You are also able to ask the nurse at your child's school for a copy of their kindergarten or 6th grade physical and immunizations and we are able to use this. These are the only grades that require updated physicals and our program adheres to the same policy. However, if your child receives updated immunizations, a new form is required.

Physical, Medical & Dietary Individual Action Plan:

This form is designed to help us properly give your child the best possible care pertaining to any special circumstances. Please complete the form and sign and date the bottom of the form.

Colonial Sports Summer Day Camp Registration

Camper Name: _____ Age _____ Email: _____

Instructions:

1. Complete one form for each child. **Pre-registration is required. A registration fee is required per family.**
2. Check the desired weeks on that section of the form.
3. A non-refundable deposit of \$25.00 per week is required at the time of registration or space will not be held, this is applied to that week's fees.
4. Payment for each week is due in full on Monday of camp session. ****No Refunds **No Pro-Rating There is a \$30.00 return check fee.**
5. Field Trips are an additional charge to the regular camp session.
6. Over-Time: **Hours exceeding 9 1/2 hours per day is an additional fee of \$25.00 per week or \$5.00/day (day rate)**
7. **Payment can be made with VISA, MasterCard, Cash or Check.** Please make checks payable to **Colonial Sports.**

Parent's Initials that they have read the Instructions

<input type="checkbox"/> Registration Fee \$ _____ <input type="checkbox"/> Regular: \$168/week <input type="checkbox"/> Daily Rate: \$42/child <input type="checkbox"/> After-School Member: \$148/week <input type="checkbox"/> 10% Discount <input type="checkbox"/> \$5 discount per week w/5 week commitment	Notes: 	T-Shirt Size: Y A sm med lg xl
		Group: _____

Camp Week	Selected Days/Week (ie: M-W-F)	Total FEE	Deposit Paid	Payment Method	Date Paid	Staff	Balance Due Amt	Balance Paid	Payment Method	Date Paid	Staff	Field Trip \$
Dates	✓	\$ _____										✓ Paid
1	6/11-15	\$	\$	cc ck cash	/		\$	\$	cc ck cash	/		\$12
2	6/18-22	\$	\$	cc ck cash	/		\$	\$	cc ck cash	/		\$20
3	6/25-29	\$	\$	cc ck cash	/		\$	\$	cc ck cash	/		\$20
4	7/2-6 *Closed 7/4	\$	\$	cc ck cash	/		\$	\$	cc ck cash	/		
5	7/9-13	\$	\$	cc ck cash	/		\$	\$	cc ck cash	/		\$20
6	7/16-20	\$	\$	cc ck cash	/		\$	\$	cc ck cash	/		\$20
7	7/23-27	\$	\$	cc ck cash	/		\$	\$	cc ck cash	/		\$20
8	7/30-8/3	\$	\$	cc ck cash	/		\$	\$	cc ck cash	/		\$20
9	8/6-10	\$	\$	cc ck cash	/		\$	\$	cc ck cash	/		\$20
10	8/13-17	\$	\$	cc ck cash	/		\$	\$	cc ck cash	/		\$20
11	8/20-24	\$	\$	cc ck cash	/		\$	\$	cc ck cash	/		\$12

How did you hear about Colonial Sports School Year Program?
 Returning Parent Website About Families Clipper Other _____

Child lives with (circle one): Mother Father Both Parents Other _____

Does your child have an IEP (Individual Education Program)? YES NO	(Please Note: If Applicable, a copy of the full IEP must be turned in at least 5 days prior to your child's first day of attendance and may require meeting with the staff before care begins.)
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Medical Waiver: We understand that in case of emergency and we are unable to be contacted, we give permission to Colonial Sports to authorize any emergency action necessary to insure the safety of our child. This does not in any way hold CHB Sports, Inc. financially responsible or otherwise liable for any medical or emergency care given. Which hospital do you wish to use if need be?

Hospital: _____

I grant permission for my child to participate and be photographed in any and all activities. I grant permission for the photographs to be used in any Colonial Sports publication. **YES** **NO**

Waiver: I hereby waive and release any and all rights for myself, my heirs, executors, and administrators this enrollee may have against CHB Sports, Inc. or its representatives, agents, and successors for any and all the injuries the participant may suffer in connection with his/her participation in any Colonial Sports Programs.

Parent or Guardian Name (Printed)	Parent or Guardian Name (Signature)	Date
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Colonial Sports Summer Day Camp Program

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT \$	PER-DAY-WEEK	DAY PAYMENT TO BE MADE Monday
Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)		
Colonial Sports Summer Camp Program provides the proper balance of fun, learning, and exercise in a safe and structured environment for school age children.		
The program includes a variety of activities, with an afternoon snack, and outdoor play.		
Supervision is provided by qualified staff.		
CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE \$ 1.00	PER MIN-HR per minute	
Extra services to be provided at an additional fee if applicable		

I, the parent/guardian;

received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)

agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum. (§ 3270.124, 3280.124, 3290.124)

_____ SIGNATURE-OPERATOR DATE SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION
DATE OF WITHDRAWAL

PERIODIC REVIEW	
_____ SIGNATURE-PARENT OR GUARDIAN	_____ DATE

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:
<input type="checkbox"/> I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.		
PARENT'S SIGNATURE:		

DO NOT OMIT ANY INFORMATION
 This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
 NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
 NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
 NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
 NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
 YES NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) <input type="checkbox"/> YES <input type="checkbox"/> NO	NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.						
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">VISION (subjective until age 3)</td> <td></td> </tr> <tr> <td>HEARING (subjective until age 4)</td> <td></td> </tr> <tr> <td>LEAD</td> <td></td> </tr> </table>	VISION (subjective until age 3)		HEARING (subjective until age 4)		LEAD	
VISION (subjective until age 3)							
HEARING (subjective until age 4)							
LEAD							

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

Colonial Sports Summer Day Camp Program
EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182; 3280.124 (a)(b), 3280.181 & 182; 3290.124 (a)(b), 3290.181 & 182

CHILD'S NAME		BIRTHDATE
ADDRESS		
MOTHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
FATHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE
PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS
		TELEPHONE NUMBER WHEN CHILD IS IN CARE
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE NUMBER
ADDRESS		
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)	
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS	
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS		POLICY NUMBER (REQUIRED)
PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT		
OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST - AID PROCEDURES	
WALKS AND TRIPS	SWIMMING	
TRANSPORTATION BY THE FACILITY	WADING	

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN

DATE

SIGNATURE OF PARENT or GUARDIAN

DATE

