INSTRUCTIONS FOR COMPLETION OF SUMMER CAMP PACKET

1. 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 and day you wish to register your child. Complete the lower portion of the form and sign the bottom. 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.

2. 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 near the bottom of the form for parental consent. Please make sure to sign all 6 boxes.

3. Agreement:

This is a mandated form. Please complete the following:

1. Fill in Name of Child
2. Fill in Person(s) Designated by Parent to Whom Child May be Released
3. Check box regarding program information
4. Check box regarding emergency information
5. Sign and date

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

4. 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.

5. 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.

2020 Colonial Sports Summer Day Camp Registration

Camper's Name: _____ **Email:** _____

Gender: Female _____ **Male** _____ **DOB:** ____/____/____ **Age During Summer Camp**_____

Address: _____

City:_____ **State:**_____ **Zipcode:** _____

Child lives with (check one) Mother ☐ Father ☐ Both Parents ☐ Other _____

How did you hear about Colonial Sports Summer Camp Program?

Returning Parent ☐ Website ☐ Social Media ☐ Referred by Camper ☐ _____ ☐ Other_____

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**

Does Your Child Have an IEP (Individual Education Plan)? ☐ 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.

Instructions:

1. Complete one form for each child. *Check the box below for the given week and day of desired care.*
2. **Pre-registration of $35 is required. A pre-registration fee of $50 is required per family**.
3. A non-refundable non– transferrable deposit of $25 per week is required upon registration or space will not be held.
4. $25 deposit for each registered week to be applied to weekly tuition.

☐ ***Parent's initial that you have read the instructions and hand book***

☐ **Registration Fee $** _____ ☐ **Regular : $168/Week**
☐ **Daily Rates: $42** ☐ **After-School: $148/Week**
☐ **Sibling Discount** ☐ **$25 credit w/5 week commitment applied to wk #** _____

Notes:

T-Shirt Size: **Y** **A** **Sm** **Med** **Lg** **Xl**

Camp Week	✔	Mon	Tues	Wed	Thur	Fri	Total Fee	Deposit	Date Paid	Method	Staff	Balance Due	Balance Paid	Date Paid	Method	Staff	Field Trip
Week 1: 6/1-5		☐	☐	☐	☐	☐	$	$	/			$	$	/			**$12**
Week 2: 6/8-12		☐	☐	☐	☐	☐	$	$	/			$	$	/			**$20**
Week 3: 6/15-19		☐	☐	☐	☐	☐	$	$	/			$	$	/			**$20**
Week 4: 6/22-26		☐	☐	☐	☐	☐	$	$	/			$	$	/			**$20**
Week 5: 6/29-7/3		☐	☐	☐	☐	☐	$	$	/			$	$	/			**$20**
Week 6: 7/6-10		☐	☐	☐	☐	☐	$	$	/			$	$	/			**$20**
Week 7: 7/13-17		☐	☐	☐	☐	☐	$	$	/			$	$	/			**$20**
Week 8: 7/20-24		☐	☐	☐	☐	☐	$	$	/			$	$	/			**$20**
Week 9: 7/27-31		☐	☐	☐	☐	☐	$	$	/			$	$	/			**$20**
Week 10: 8/3-7		☐	☐	☐	☐	☐	$	$	/			$	$	/			**$20**
Week 11: 8/10-14		☐	☐	☐	☐	☐	$	$	/			$	$	/			**$20**
Week 12: 8/17-21		☐	☐	☐	☐	☐	$	$	/			$	$	/			**$12**

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, and successors, for any and all injuries the participant may suffer in connection with his/her participation in a Colonial Sports Program.

- By signing this document I understand that all payments are final and all deposits are non-transferrable nor refundable.
- I agree to let the front desk know of any schedule changes the Wednesday prior. Anything after that will be subject to the initial cost for the week.

_____ _____ _____

Parent or Guardian Name (Printed) ***Parent or Guardian Name (Signature)*** ***Date***

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
ADDRESS	
FATHER'S NAME/ LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE
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 NEED OF A CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER

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

X _____ _____

SIGNATURE OF PARENT OR GUARDIAN — DATE

_____ _____

SIGNATURE OF PARENT OR GUARDIAN — DATE

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

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 is 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 guardian consent form information whenever changes occur or every 6 months at a minimum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR DATE

X SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION
DATE OF WITHDRAWAL

PERIODIC REVIEW

SIGNATURE-PARENT OR GUARDIAN DATE

PHYSICAL, MEDICAL, DIETARY

CHILD'S NAME:	PERSON FILLING OUT FORM:

If your child has any **physical, medical, dietary** or other special needs, please note them on this form. If these needs require specific care, we need a copy of the script from the doctor's office before your child starts the program**. If this form does not pertain to your child, please write "none".**

Please state the nature of the physical, medical, dietary or other special need:

Please provide signs/symptoms of the need and the course of action to be taken if symptoms are exhibited:

Please list any medications your child takes on a regular basis. If they need to be administered by our staff, please include a doctor's instructions along with the **original container of medication**. Any prescribed medication, including inhalers and EpiPens, **must be turned in prior to the child's first day of attendance**. ***We do not provide ANY medication including Benadryl, Tylenol, etc. and cannot administer ANY medication without a doctor's written instructions.***

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.)

Please list any additional information you feel we should know in order to better serve your child.

_____

_____

_____

_____

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 ensure 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: _____ **Parent Signature**: _____ **Date:** _____

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 injuries the participant may suffer in connection with his/her participation in any Colonial Sports Programs.

Parent Signature: _____ **Date:** _____

CHILD HEALTH REPORT

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

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ 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)
☐ YES ☐ 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.

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:	

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