BIG CITY DAY CAMP
ENROLLMENT FORMS

<u>Return with your confirmation letter</u> to complete your registration.

~ Type in requested data and return by clicking SUBMIT button.

~ If you have missed filling in any required fields (red box), the forms will not allow you to submit until you fill in that field.

~ A copy will automatically be saved to the "sent" folder of the email address from which you are submitting the forms.

~ Please fill forms out fully and return by March 12th (or within one week of receiving confirmation letter). We will need separate forms for each child you've enrolled. We do not transfer forms annually.

~ Buddy requests are ONLY accepted on the form provided.

JCYS Big City Day Camp
Communications Form

Child's Name: _____

Big City Day Camp will communicate important immediate information (i.e. weather-related or field trip changes) through a text to your phone and the phone of another person that you designate. People included here should be parents and/or anyone responsible for the regular pickup and drop-off of your child.

Text Alert (limit 2):

Name _____ **Cell #** _____ **Cell Carrier** _____

Name _____ **Cell #** _____ **Cell Carrier** _____

Secure Website Page (swim reports, photos, weekly newsletters, camp calendar)

Lengthier communications will be visible in our Parents Corner on the jcys.org/bigcitydaycamp website. That information will be visible only to registered users. Upon return of these forms, you become a registered user and will be sent a password. You will be able to share that password with whomever you deem appropriate. Please list two email addresses you would like to be submitted for this use.

Name _____ **Email** _____

Name _____ **Email** _____

JCYS Big City Day Camp
Parent Guardian Consent Form

Child's Name: _____

1. I request that my child be admitted to the JCYS Big City Day Camp.
2. I understand that the deposit must accompany the registration form and that it is non-refundable and non-transferable unless the child is not accepted into the program or is unable to attend due to illness as verified in writing by a physician. I further understand that the balance of the fee is due as outlined in the parent contract.
3. I understand that the enrollment forms must be filled out, signed and returned with the confirmation letter to complete the enrollment process.
4. I understand that program participants may be asked to have a personal interview with the camp director.
5. I give permission for my child to go on field trips outside of center grounds. I understand that parents will be notified in advance of these trips.
6. I understand that JCYS Michael R. Lutz Family Center or Big City Day Camp is not responsible for loss of personal property or personal injury sustained by the participant and I hereby agree to indemnify and hold harmless JCYS Michael R. Lutz Family Center or Big City Day Camp from such losses or injuries.
7. I give permission for the above named participant to go on out-of-facility field trips and to be included in photos and videos for publicity purposes in a variety of media, including but not limited to, brochures, advertisements, social media and the JCYS web-site.
8. I understand that in the event of a minor accident involving my child I will be notified to pick him/her up as soon as possible so that s/he may receive the necessary medical attention. In the event that I am unavailable, the emergency contact(s) listed on my child's registration form will be called.
9. In the event of emergency, if the center cannot reach me, or emergency contacts named, I authorize the camp director to act for me according to his/her best judgment. I hereby give permission to the appropriate medical personnel selected by the camp director, to provide medical treatment deemed necessary by such medical personnel, including x-rays, tests, injections, hospitalization, anesthesia and surgery.
10. I have read and understand the policy and procedure guidelines for the care of children involved in a serious medical emergency and I agree to abide by them. I understand that should my child become ill or feverish I will be notified to pick him/her up as soon as possible. I also understand that if I am not available the emergency contact(s) listed on my child's registration form will be called.
11. I understand that it is my responsibility to keep all of the parent/guardian phone numbers and the names and phone numbers of emergency contact(s) up to date and accurate and I will inform the center should there be any changes.
12. I understand that Big City Day Camp celebrates Shabbat each Friday.
13. I have read the Parent Handbook and agree to the policies within it, especially the late pickup policy, discipline policy, illness policy, and lunch and supply policies.

By selecting the "I Agree" button, you are confirming that you are the Parent/Legal Guardian of the above named child and that you are signing this document electronically, therefore you consent to be legally bound to the intent of this document.

JCYS Big City Day Camp Camper Intake Form

Camper's Name _____ DOB

1. Physical Development:
   Is your child a finicky eater? Yes No Describe
   Allergies? Yes No Describe
   Food restrictions? Yes No Describe
   Vision or hearing difficulties? Yes No Describe
   Special medications? Yes No Describe

2. Has your child ever experienced any of the following: serious illness, accidents, hospitalization, seizures?
   Yes No Describe

   Detail how anything listed above may affect your child during camp activities:

   Is there anything else about your child's physical development which we should know? Yes No
   Describe

3. Social and Emotional Development:
   Please describe any recent family changes and any pertinent effect on your child's mental well-being (new job, new home, new sibling, family death, serious illness, etc.)

   Do you expect your child to have separation difficulty upon entering this program? Yes No If yes, what are some suggestions for our staff?

   Does your child have any fears or phobias? Yes No Suggestions to help your child be more comfortable?

   Is there anything else about your child's social and emotional development which we should know?
   Yes No Please describe _____

By selecting the "I Agree" button, you are confirming that you are the Parent/Legal Guardian of the above named child and that you are signing this document electronically, therefore you consent to be legally bound to the intent of this document.

JCYS Big City Day Camp Parental Best Practices Agreement

CAMPER'S NAME_____

Big City Day Camp is committed to providing the best camp experience for you and your child. Thank you for creating a strong partnership with us in the best interest of your child.

Parental Responsibilities:

1) I agree to return all camp enrollment forms, tuition and any additional paperwork that is distributed during the camp session by stated deadlines.

2) I acknowledge receipt of the Parent Handbook which outlines procedures for illness, the probation period, and pickup and drop-off times and procedures.

3) I agree to provide best practices in writing for any of my child's medical or behavioral needs that the staff can employ to create a successful situation for my child. If in the event, during the course of the camp session, the director feels that a meeting is necessary, I agree to set a time to meet within a day of any incident that may have occurred.

4) I agree to provide my child with all necessary supplies on a daily basis, including appropriate closed-toe shoes, sunscreen, a lunch, a water bottle, a bathing suit and towel, and a change of clothes. If lunch is forgotten, I agree to bring it to my child at whatever location the camp may be, or if I am unable to, I will give verbal permission to the camp director or unit head to purchase lunch. In the event of staff purchasing lunch, I will reimburse the staff at pick-up that day.

5) I agree not to solicit or hire any camp staff while my child/children are enrolled in JCYS programs.

6) I agree to discuss any concerns regarding staff, another camper or parent in a private, respectful manner by bringing the situation to the attention of the director away from the area of the campers and at an appropriate, agreed upon, time. I also agree to work toward a reasonable and timely solution with all parties.

7) I agree to label my child's supplies, and make my child aware of the supplies in their possession. Big City Day Camp will remind campers to pick up their items, but is not responsible for picking up after campers. A lost and found box is available to parents every week. JCYS is not responsible for lost or stolen items.

8) I am aware that communications from BCDC are primarily through its email or through its website, jcys.org/bigcitydaycamp. I agree to selectively share the password for the Parents Corner pages with appropriate parties as needed. I will keep JCYS apprised of any change in email my address. In the event that email communication is not convenient or available to me, I will notify the director at the beginning of summer so that other arrangements can be made to get communications to me.

I have read, understand and will abide by the Parental Best Practices as outlined above. I will also provide this information to all parties responsible for my child during the camp season.

By selecting the "I Agree" button, you are confirming that you are the Parent/Legal Guardian of the above named child and that you are signing this document electronically, therefore you consent to be legally bound to the intent of this document.

JCYS Big City Day Camp Authorization For Pick-Up Form

Child's Name_____

The following people listed below have my authorization to pick up my child. (Please include yourself; child's other parent, relatives, friends, baby-sitters, or anyone else who might pick up your child. For each name listed include a phone number and relationship to child.) PLEASE LIST CONTACT INFORMATION IN THE ORDER WE ARE MOST LIKELY TO REACH YOU (i.e. Cell, work, home)

Parent/Legal Guardian: Name:
Phone:
Phone:
Relationship:

Parent/Legal Guardian: Name:
Phone:
Phone:
Relationship:

Name:
Phone:
Relationship:

Name:
Phone:
Relationship:

Name:
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Relationship:

Name:
Phone:
Relationship:

<u>Children will not be released to anyone not on this list.</u> I understand that it is my responsibility to update this form whenever necessary.

By selecting the "I Agree" button, you are confirming that you are the Parent/Legal Guardian of the above named child and that you are signing this document electronically, therefore you consent to be legally bound to the intent of this document.

JCYS Early Childhood Assumption of Risk & Waiver Agreement

I/We, _____, as parent(s) or legal guardian(s) of the below named minor, hereby give my/our permission for this child or legal ward to participate in a program at Jewish Council for Youth Services (JCYS).

I/We accept that there are inherent risks involved in attending a JCYS program, which risks we expressly assume. If applicable I/We have advised JCYS, and our health care provider has confirmed, that my child suffers from various allergies and/or other conditions as reported in the attached Medical Treatment Forms.

I/We acknowledge that while JCYS will endeavor to follow any directions given to it by the health care provider and contained on the Medical Treatment Form, I/we are aware that JCYS does not employ a nurse or other health care professional at its camps, and is not required to do so. I/We understand that all reasonable precautions are taken to ensure that all JCYS programs are conducted in a safe and responsible manner. I/We further specifically authorize JCYS and its employees, staff and agents, on my/our behalf and in my/our stead, to administer or attempt to administer to my child (or to allow my child to self-administer) lawfully prescribed medication and health services set forth in the Medical Treatment Forms.

I/We understand that JCYS shall not be responsible for loss of personal property, personal injury or loss of life by my/our above-mentioned child and hereby agree to assume all risks, current and future, known and unknown, in connection with and arising from my/our above-mentioned child's participation in any JCYS program. I/We hereby forever release and waive any and all claims, causes of action and rights I/we may have as a result of any personal injury, loss of personal property or loss of life I/we may have against, on our own behalf or on behalf of our child or legal ward, JCYS, its directors, officers, agents, servants and employees, and further agree to indemnify, defend and hold harmless JCYS, against any and all such claims that may be brought against it, or its directors, officers, agents, servants and employees as a result of or arising from such losses or injuries, arising out of or resulting from our child or legal ward's participation in any JCYS program.

CHILD'S NAME: _____

By selecting the "I Agree" button, you are confirming that you are the Parent/Legal Guardian of the above named child and that you are signing this document electronically, therefore you consent to be legally bound to the intent of this document.

JCYS Big City Day Camp
Emergency Action Consent Form
**** (Must be filled out for every child) ****

Policy and Procedures for the Care of Children Involved in a Serious Emergency

When a child is injured or becomes ill while at the JCYS Big City Day Camp, our first consideration is to ensure the health and safety of the child. The following is an explanation of the procedures we generally adhere to in the event of a medical emergency. However, depending on the specific situation, staff may depart from these procedures if it is determined by staff to be in the best interest of the child.

1. When a child becomes seriously ill or injured, the paramedics will be called immediately so that medical attention and/or assessment can be obtained.
2. The parents will also be contacted immediately. If neither parent is available, the emergency contacts listed on the child's registration will be contacted, including the physician named on the registration form.
3. If the parent or emergency contact is reached, they will be apprised of the situation, including the paramedic's recommendation for treatment.

If the situation is not considered to be life endangering by the paramedics, the parent or emergency contact will be given the following choices:

1. The child will be moved to the nearest approved hospital by the paramedics (accompanied by lead staff or director of the camp). The nearest hospitals to the center are Illinois Masonic, Louis Weiss and Thorek Hospital. The parent or emergency contact will meet the ambulance at the hospital emergency room; or
2. A private ambulance will be called, at the parent's expense, and the child will be taken to the hospital of the parent's choice (accompanied by lead staff or the camp director). The parent or emergency contact will meet the ambulance at the emergency room; or
3. If the parent or emergency contact can reach the Center within approximately 10 minutes and the paramedics agree to stay on the premises until the parent or emergency contact arrives the child will be released to the parent or emergency contact and the child's care will then be the responsibility of that person; or
4. If the parent or emergency contact cannot or does not arrive within 10 minutes or the time allotted by the paramedics, the paramedics will take the child to the nearest approved hospital (accompanied by lead staff or the camp director). When the parent or emergency contact arrives at the camp, they will be informed as to where the child has been taken.

If, in the sole opinion of the paramedics, the situation is considered to be life endangering, the paramedics will secure treatment for the child as they deem necessary. (In a severe emergency, paramedics are usually instructed by their supervisor to take a child to Ann & Robert H. Lurie Children's Hospital of Chicago, but the decision is not usually left to the parent.) The parent or emergency contact will be informed as to where the child will go and meet the ambulance at the hospital emergency room.

If a parent or emergency contact cannot be reached, the paramedics will secure treatment for the child at the nearest hospital. Efforts to reach a parent or emergency contact will continue until contact is made.

I agree to the following emergency protocol for (Child's Name) _____:
Call 911 (unless contraindicated by physician in treatment plan) and state allergen/emergent condition and steps taken.

1) Call Emergency contacts:

Name	Relationship	Phone Number #1	Alternate phone number

2) Call Child's Doctor if applicable(Name)_____Phone Number_____

By selecting the "I Agree" button, you are confirming that you are the Parent/Legal Guardian of the above named child and that you are signing this document electronically, therefore you consent to be legally bound to the intent of this document.

**BUDDY REQUEST FORM 2014 **

Buddy requests will only be honored if documented on this form.

No requests accepted after May 1st

Buddy requests are a chance to request an enrolled friend to be in the same counselor group as your camper. Keep in mind that campers spend lots of time together, regardless if they are in the same counselor group. We highly encourage campers to meet new friends as they explore new adventures. If your camper does not feel strongly about having a friend in their group, please do not request a buddy.

BUDDY REQUESTS ARE NOT GUARANTEES; MANY FACTORS REGARDING GROUP DEMOGRAPHICS AND DYNAMICS ARE TAKEN INTO CONSIDERATION BEFORE ASSIGNING GROUPS. I WILL DO MY BEST TO HONOR A REQUEST. PLEASE ONLY INCLUDE ONE NAME. THANKS FOR YOUR UNDERSTANDING.

Buddies MUST be in same age group – **Trekkers = K**
Wheelers = 1st & 2nd
Fliers = 3rd & 4th
Rovers = 5th thru 8th graders

Camper's Name_____ Camp Age Group Name _____

Camper is entering grade _____ in the fall of 2014

Name of Buddy Requested (one name only, or the choice will be made based on group demographics)

_____

My camper is enrolled for the following weeks (check all that apply):

Week 1 ☐ Week 2 ☐ Week 3 ☐ Week 4 ☐ Week 5 ☐ Week 6 ☐ Week 7 ☐ Week 8 ☐

Non-electronic Forms

The following forms need actual signatures. They must be signed, scanned and emailed back to bcdcadmin@jcys.org, or printed and mailed back to:

Big City Day Camp ~ Attn: Lys
957 W. Grace
Chicago, Il 60613

For all campers:

- The swim waiver is for swim lessons at FFC and must be signed for each camper.
- The immunization forms should be a copy of the most recent you have; you do not need to wait for an upcoming doctor's appointment.

For Campers with Medical Needs:

- If your child has allergies or any other diagnosed conditions, the treatment plan form must be filled out and signed by a physician. If the medication form applies, that must be physician signed as well. If neither of these forms are applicable, you do not need to send them in.

Optional for all:

- Tuition express is a convenient payment option. It allows for tuition payments to be withdrawn automatically from a checking account or charged to a credit card. We do not accept American Express. Complete and return this only (with a canceled check if applicable) if you want to use this plan.

FINAL STEPS:

1. Print the following forms, complete, sign and return to above address.
2. Scroll down through forms and click {SUBMIT} to send the electronic forms.

Member Activities Participation Waiver

Participant Name_____

Address_____ **City**_____ **State**_____ **Zip**_____

Phone_____ **Email**_____

Emergency Contact_____ **Phone**_____

I, the undersigned ("Participant), in consideration for FFC allowing my participation in a FITNESS FORMULA CLUB group event or birthday party (the "Programs"), agree to the following:

Waiver of Liability
Participant understands that although the facilities, equipment and services of FFC and the Programs are designed to provide a safe level of beneficial exercise and enjoyment, there is an inherent risk that use of such facilities, equipment, services and participation in the Programs may result in injury. Therefore, Participant agrees to specifically assume all risk of injury for Participant while Participant is using any of FFC's facilities, equipment, services or participating in the Programs and hereby waives any and all claims or actions that may arise against FFC, its owners, employees, contractors, or volunteers as a result of such injury. These risks include, but are not limited to: (1) Injuries arising from Participant's use of any equipment in connection with the Programs, whether occurring inside or outside of FFC, (2) Injuries arising from Participant's transportation to and from a site that is a part of the Programs, (3) Injuries or medical disorders arising from Participant's participation in the Programs, whether occurring within or outside of FFC and (4) actions taken or decisions made from FFC, its staff members, volunteers or chaperones regarding medical or survival procedures for Participant.

Assumption of Risk
Participation in the Programs naturally may involve the risk of injury, whether Participant or someone else causes it. As such, the undersigned agrees that he or she understands and voluntarily accepts this risk on behalf of Participant and agrees that FFC will not be liable for any injury, including and without limitation, personal, bodily or mental injury, economic loss or any damage to Participant resulting from negligence or other acts of FFC or anyone else using the facilities or participating in Programs. If there is any claim by anyone based on any injury, loss or damage described herein, which involves Participant, the undersigned agrees to (i) defend FFC against such claims and pay FFC for all expenses relating to the claim and (ii) indemnify FFC for all obligations resulting from such claims.

I, the undersigned parent or legal guardian of the participant hereby execute the foregoing Waiver of Liability and Assumption of Risk for and on behalf of Participant and agree to bind myself, Participant and any heirs, next of kin, assigns or personal representatives to the terms of the Waiver of Liability and Assumption of Risk. I represent that I have full legal authority to act for and on behalf of Participant, and I agree to indemnify and hold harmless FFC for any expenses, claims or liabilities that may arise as a result of any insufficiency of my full legal authority to execute the foregoing Waiver of Liability and Assumption of Risk

Signature _____ **Name** _____ **Date** _____

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles** / **Rubella** / **Mumps**					
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) **☐Measles** **☐Mumps** **☐Rubella** **☐Hepatitis B** **☐Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																						
Age/ Grade																						
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L		
Vision																						
Hearing																						

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

Last	First	Middle	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION** (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma? Child wakes during night coughing?	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No		
Developmental delay?	Yes No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No		
Diabetes?	Yes No		Serious injury or illness?	Yes No		
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.	
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No		
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No		
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No		
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No		
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes.			
Bone/Joint problem/injury/scoliosis?	Yes No		**Parent/Guardian Signature**		**Date**	

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING **(NOT REQUIRED FOR DAY CARE)** **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.

Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed ☐** **Test performed ☐**

Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm _____

Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value _____

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes ☐ No ☐ Limited ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete Both Sides)

Jewish Council for Youth Services
Medical Emergency Treatment Consent Form
For campers with allergies and diagnosed conditions only.

Camper's name: _____ D.O.B: _____

Doctor's signature or stamp (required): _____ Date: _____

This section to be completed by the physician. **Note: If multiple food allergies, can combine in one section if treatment plans are identical.** **Use more than one form if there are more than three treatment plans.**
ALLERGY/EMERGENT CONDITION (e.g., asthma, seizure) **#1:** **If allergy:** **Life-threatening? Circle YES or NO** **Contact or Ingestion? Circle CONTACT or INGESTION**
SYMPTOMS:
TREATMENT PLAN (including medication/dose/route): If non-life-threatening allergy, check here ____ if 911 should not be called automatically.
ALLERGY/EMERGENT CONDITION (e.g., asthma, seizure) **#2:** **If allergy:** **Life-threatening? Circle YES or NO** **Contact or Ingestion? Circle CONTACT or INGESTION**
SYMPTOMS:
TREATMENT PLAN (including medication/dose/route): If non-life-threatening allergy, check here ____ if 911 should not be called automatically.
ALLERGY/EMERGENT CONDITION (e.g., asthma, seizure) **#3:** **If allergy:** **Life-threatening? Circle YES or NO** **Contact or Ingestion? Circle CONTACT or INGESTION**
SYMPTOMS:
TREATMENT PLAN (including medication/dose/route): If non-life-threatening allergy, check here ____ if 911 should not be called automatically.

JEWISH COUNCIL FOR YOUTH SERVICES

CONFIDENTIAL PERMISSION FORM FOR **MEDICATION ADMINISTRATION**

(Parent must meet with camp director prior to start of camp.)

CHILD'S NAME: _____ BIRTHDATE: _____ AGE: _____

ADDRESS:_____

PARENT/GUARDIAN PHONE: Mobile _____ Work _____ Home_____

PHYSICIAN NAME & PHONE_____

PHYSICIAN'S ORDER: (This section to be filled out by physician.)
Indication for Medication:

Name of Medication:

Dosage and Directions for Use:

Possible Side Effects and Response Required:

Child may attend school/camp _____ Child may return to school/camp on _____

Physician Signature: _____ Date: _____

Print Physician Name & Address:

_____

I hereby confirm my primary responsibility to administer medication and provide health services to my child. However, in the event that I am unable to do so, I hereby authorize Jewish Council for Youth Services and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child, or allow my child to self-administer while under the supervision of the employees and agents of JCYS, the above listed/identified lawfully prescribed medication and health services in the manner described above. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS AND DELIVERY OF HEALTH SERVICES TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A CERTIFIED NURSE OR HEALTH AIDE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I further acknowledge and agree that, when the lawfully prescribed medication or health services are so administered, or attempted to be administered, I waive any claim I might have against JCYS, its employees and agents arising out of the administration of said medication or services. In addition, I agree to hold harmless and indemnify JCYS, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication or health services.

Parent/Guardian Signature _____ Date _____

REVIEWED: M Goldsmith 12/20/2006

TUITION Express
ProCare Software

Hop aboard the Tuition Express and never write a check again!

As your childcare provider, we are excited to offer you the convenience of automatic tuition payments through Tuition Express. You'll no longer need to write a check or remember your checkbook when you're picking up your child at the end of a hectic day. Your payment will be safely and securely processed by Tuition Express, giving you peace of mind that your tuition has been paid on time! It's easy to enroll and even easier to participate. You'll be joining tens of thousands of parents nationwide who enjoy the ease and convenience of Tuition Express.

To learn more about Tuition Express, automatic payment notifications or reviewing your payment history, please visit www.tuitionexpress.com.

For Bank Account Authorization, complete and return to center management.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION

I (we) authorize _____ , (called "CENTER" in this Authorization) to initiate debit entries to my (our) Checking or Savings Account indicated below at the depository financial institution indicated below (called "DEPOSITORY" in this Authorization). I (we) authorize CENTER to withdraw sufficient funds to pay my (our) regular childcare tuition and/or other childcare related fees that are due and payable. I (we) authorize CENTER to use the third party sender, Tuition Express* to process all payments. I (we) acknowledge that the origination of Automated Clearing House (ACH) transactions to my (our) account must comply with the provisions of United States Law.

Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments.

_____	_____	_____
Your Name	Phone #	DEPOSITORY - Bank or Credit Union Name
_____		_____
Address		Bank or Credit Union Address
_____		_____
City	State Zip	City State Zip
		Type: ☐ Checking ☐ Savings
_____		_____
Routing Transit Number (see sample below)		**Account Number** (see sample below)

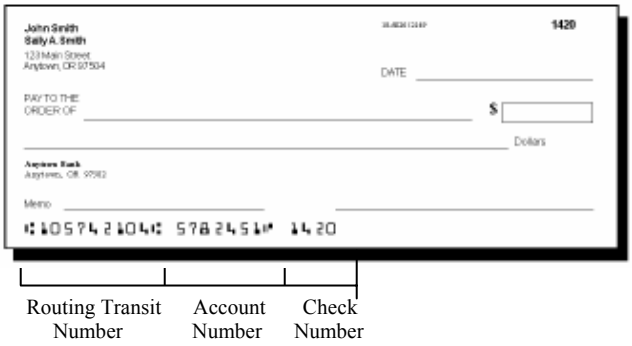
This authorization will remain in full force and effect until I (we) notify the CENTER in writing of its termination in such time and in such manner as to afford Tuition Express and DEPOSITORY a reasonable opportunity to act upon it. Notices must be received at a minimum of 5 business days in advance of the termination date.

_____ _____

Signature Date

Record Retention Notice: The child care provider shall retain all parent (client) authorization forms in a secure location for a period of two years from the date of client withdrawal from the Tuition Express™ program.

*Tuition Express is an assumed business name of Blum Investment Group, Inc.



Please attach a copy of a voided check here. Deposit slips not accepted.

TUITION Express
ProCare Software

For Credit Card Authorization, complete and return to center management.

CREDIT CARD PAYMENT AUTHORIZATION

I (we) hereby authorize _____ (called "CENTER" in this Authorization) to initiate recurring credit card charges to the below referenced credit card account for the purpose of collecting childcare related payments. I (we) understand that the charges to the below referenced credit card account will be based on charges that are due and payable at the time of the credit card transaction. I (we) understand that this agreement is between myself (us) and the below referenced "CENTER". I (we) authorize CENTER to utilize Tuition Express* to capture, create, and transmit all credit card information. I (we) indemnify and hold harmless, Tuition Express from any and all liability resulting from any and all transactions. All disputes will be directed to and addressed by and between CENTER and the below signed cardholder. **I (we) understand that to properly affect the cancellation of this agreement, I (we) are required to give CENTER written notice of revocation. A minimum of 5 business days is required to affect revocation.**

PLEASE CONTACT CENTER REPRESENTATIVES FOR CREDIT CARD TYPES ACCEPTED BY CENTER.

_____ _____
Cardholder Name Phone #

_____ _____
Cardholder Billing Address Account Number

_____ _____
City State Zip Expiration Date

_____ _____
Cardholder Signature Date

*Tuition Express is an assumed business name of Blum Investment Group, Inc.

For Official Use Only:

Date Received: _____

Employee Signature: _____

Record Retention Notice: The child care provider shall retain all parent (client) authorization forms in a secure location for a period of two years from the date of client withdrawal from the Tuition Express™ program.