Neighbor to Neighbor CDC
Camp Joy/#Camp Joy 2
814 Clifton Avenue Sharon Hill, PA 19079
Office Tel. 610-461-8140 Site Tel. 610-461-8015
www.n2ncdc.org

Registration Form

Camper's Name: _____ Gender: M/F_____
Please Print

Age: _____ DOB: _____ Grade in Sept: _____ Shirt size:_____

School Attending in September_____

Address: _____

City: _____State: _____ ZIP:_____

Home Phone Number: _____ Cell # _____

Email: _____
Please Print

Mother's Name:_____ Cell #:_____

Father's Name:_____ Cell#:_____

Emergency Contact: _____

Relationship:_____ Cell#:_____

The cost of camp is $130.00 per week, first child, plus $90.00 per week for each additional child residing in the same household. A $60.00, non-refundable, registration fee is required at the time of registration for each family. **CCIS is accepted**. Ask about our registration fee waiver. Please check camp and weeks your child will be attending.

Week 1		**Week 2**		**Week 3**		**Week 4**		**Week 5**	
July 10-14		July 17-21		July24-28		July 31-Aug 4		Aug 7-11	

Parent Signature _____ Date: _____

Staff Signature:_____ Date:_____

#Campjoy2reg2017

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:

☐ 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:	LICENSE NUMBER: DATE FORM SIGNED:

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

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)
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

_____ _____

Neighbor to Neighbor
Camp Joy/#Camp Joy

MEDIA/VIDEO RELEASE

Neighbor to Neighbor Community Development Corporation would like your permission to take photos/videos of your child to be used in a promotional display, brochure or marketing materials. We will only use your child's image and never publish their name. Please complete the information below.

I do_____/do not_____

give permission for _____ to be
Print Child's Name

photographed/videotaped by Neighbor to Neighbor Community Development Corporation which may be published or used in promotional displays, brochures or marketing materials.

_____ Date:_____
Parent/Guardian Signature

Neighbor to Neighbor
Camp Joy/#Camp Joy 2
Swimming Permission Slip
Nile Swim Club of Yeadon

Name of Camp: _____

I, _____ give permission for my
Print Parent/Guardian Name

daughter/son _____
Print Child's Name

to participate in camp activities at the **Nile Swim Club of Yeadon.** I understand that the **Nile Swim Club of Yeadon** is only providing recreational swim time for the camp and will not be liable for any property that is lost, misplaced or stolen. I also release the **Nile Swim Club of Yeadon** from any injury that may occur while using the facility. Any damages that incur to the **Nile Swim Club of Yeadon** or its property, including staff, as a result of my child's actions will become my financial obligation. I understand the **Nile Swim Club of Yeadon** will prosecute to receive full compensation.

I also understand that it is the responsibility of my child's camp to provide transportation to our facility and supervision of my child at the Nile Swim Club of Yeadon.

_____ Date_____
Parent/Guardian Signature

Neighbor to Neighbor
Before and After Care Program

Camper's Name:_____

Mother's Name:_____ Cell #:_____

Father's Name:_____ Cell#:_____

Emergency Contact:_____

Relationship:_____ Cell#:_____

Fees

- Before Care (7:30am-9:00am) $25.00 per week/per family
- After Care (3:00pm-6:00pm) $35.00 per week/per family
- Before Care and After Care $50.00 per week/per family
-

Late fees of $1.00 will be assessed for campers picked up after 6:05pm in 5 minute intervals (ex. 6:10pm-$1.00, 6:15pm-$2.00).

Please check the appropriate box/s if your child will be attending this program.

Week 1		**Week 2**		**Week 3**		**Week 4**		**Week 5**	
Before care		Before care		Before care		Before care		Before care	
After Care		After care		After care		After care		After care	

Parent Signature:_____ Date:_____

Staff Signature:_____ Date:_____