

# TOWN OF RAMAPO

## Summer Camp Registration Form 2024



PARENT/GUARDIAN NAME & PHONE:	Name:	Contact #: ( )
PARENT/GUARDIAN NAME & PHONE:	Name:	Contact #: ( )
FULL ADDRESS:	Address:	City, State & Zip Code:
EMAIL ADDRESS & ADD'L PHONE:	Email:	Phone #: ( )
EMERGENCY CONTACT:	Name:	Contact #: ( )

### Camper Information (One form per child):

Camper's Last Name, First Name		Date of Birth
School Attending – Fall 2024		Grade – Fall 2024
		Gender (Circle One)  M or F

### Camp Options: check ✓ all that apply

CAMP SCUFFY		MONDAY – FRIDAY		
KINDERGARTEN	Grade K	9:00am – 3:30pm	\$1600	
JUNIORS	Grades 1 - 6	9:00am – 3:30pm	\$1600	
TEENS	Grades 7 - 9	9:00am – 3:30pm	\$1700	
EXTENDED DAY	Grades K - 9	3:30pm – 5:30pm	\$250	

CREATE & EXPLORE		MONDAY – FRIDAY		
Create & Explore	Grades 1 - 8	9:00am – 3:30pm	\$850	
Create & Explore EXTENDED DAY	Grades 1 - 8	3:30pm – 5:30pm	\$200	

SPORTS CONDITIONING		MONDAY – FRIDAY		
Sports Conditioning	Grades 6 - 10	9:00am – 3:00pm	\$900	

TEEN TREK		MONDAY – THURSDAY		
Teen Trek	Grades 7 - 9	9:00am – 3:00pm	\$1400	

CIT PROGRAM held at Mini Camp sites – make location preference below				MONDAY – FRIDAY	
First Choice _____	Second Choice _____	Grades 9 & 10	8:30am – 1:30pm	\$500	

MINI CAMPS* *LOCATIONS SUBJECT TO CHANGE		MONDAY – FRIDAY		
Suffern Middle School *	Pre-K - Grade 5	9:00am – 1:00pm	\$400	
Suffern High School *	Pre-K - Grade 5	9:00am – 1:00pm	\$400	

NON-RESIDENT FEE INCREASE:		
Camp Scuffy		ADD \$250
Sports Conditioning, Teen Trek, Create & Explore		ADD \$125
Mini Camps		ADD \$100

Camper's Name: \_\_\_\_\_

**PICK- UP & EMERGENCY INFORMATION:**

In the event that there is an emergency at camp, and you cannot be reached, please list additional individuals (18 and over), who are authorized to pick up your child. Please remind all to have a photo ID ready to display for pick up. We will not release your child to any other individual without written permission.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**IMMUNIZATION RECORDS: Required by NYS - Attach current records with a doctor's signature or stamp.**

**MEDICAL INFORMATION:**

Doctor: \_\_\_\_\_ Phone#: \_\_\_\_\_

Known Allergies: \_\_\_\_\_

Medical Comments: \_\_\_\_\_

Please provide any additional information about the camper's physical, emotional, or mental health of which the camp staff should be aware: \_\_\_\_\_

**SUMMER CAMP TRIPS:** I understand that by signing this form I agree for my child to attend all trips listed on camp calendar including any water related trips.

**DEPT. OF HEALTH GUIDELINES:** In New York State, summer camps must have a state, city or county health department permit to operate legally. These permits are issued only if the camp is in compliance with the state's health regulations. The permit to operate must be displayed in a conspicuous place on the premises. The camp must be inspected twice yearly by a health department representative. At least one inspection must be made during the time the camp is in operation. Each camp is checked to make sure that the physical facilities are safe, and that supervision is adequate.

**AUTHORIZATION:** I authorize that the above information is accurate and current, and all information has been filled out by the appropriate parties. In the event that I cannot be reached, and an emergency occurs, I hereby give permission to the physician selected by the Town to hospitalize and secure treatment for my child. I understand that the Town of Ramapo does not offer accident insurance and my personal insurance bear's primary responsibility in case of an accident. I will allow photos for promotion.

Parent/Guardian Signature

Date

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION: All campers who need medication administered during camp hours must have the following completed by a physician. Medication must be in original container, contain a prescription & will be administered by camp nurse. For camps without a nurse, medication will be self-administered.**

Name of Medication(s), Dose & Method of Administration: \_\_\_\_\_

Specific date(s) & time(s) to be given: \_\_\_\_\_ Or Issue Only as Needed: \_\_\_\_\_

Physician's Name & Phone Number: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_