REACH
SUMMER
CAMP

2018 Summer Program Application

Staff Use Only Staff Initial_____

Date_____ CC Cash Check#_____

Deposit $_____ TOTAL PAID $_____

Registration Checklist

- **Immunization Record (non-REACH students only)**
- **Payment**

Child's Name _____ Home Phone _____

Address _____ City _____Zip_____

Age: _____ Date of Birth: ____/____/____ Gender: M / F CURRENT GRADE: _____School_____

Guardian/Father's Name_____ Guardian/Mother's Name_____

Place of work: _____Place of work_____

Work phone_____ Work phone #_____

Cell Phone_____ Cell Phone_____

Does your child suffer from any MEDICAL problems: Yes or No. If yes please explain_____

_____

Does child take any MEDICATIONS? Yes or No If so, what kind: _____

Does child have any DISABILITIES? If so, please explain: _____

Name of Doctor_____ Phone #_____

EMERGENCY CONTACT INFORMATION OTHER THAN PARENTS'/GUARDIANS'

Name: _____ Relation _____ Phone _____

Name: _____ Relation _____ Phone _____

Does this person have permission to pick up your child? Yes No

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2018 Summer Camp - Health Examination Form

THIS FORM MUST BE COMPLETED BY PARENTS

Child's Name:_____ D.O.B.: _____ Sex: ____ Age: _____

Parent/Guardian Name: _____

Address: _____Phone# _____

Place of business_____ Phone#_____

IN AN EMERGENCY, NOTIFY:

Name _____ Phone _____

Address _____ City _____

Name _____ Phone _____

Address _____ City _____

Operations or serious injuries and dates_____

Chronic or recurring illness or medical condition_____

Dietary restrictions_____

Diseases_____

Dentist/Orthodontist Name _____Phone _____

Family Physician Name_____ Phone _____

DO YOU CARRY FAMILY MEDICAL/HOSPITAL INSURANCE? YES OR NO

Carrier _____ Policy/Group# _____

Carrier Address_____ City _____ St_____

SUGGESTIONS ON HEALTH RELATED INFORMATION FOR CAMP PERSONNEL

Parents Authorization - this health history is correct so far as I know, and the person herein described has permission to engage in all prescribed club activities except as noted by me and the examining physician. I hereby give permission to the physician selected by the Camp Director to order x-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for and to order infection and/or anesthesia and/or surgery for my child as named above.

Signature_____ Date_____

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2018 SUMMER CAMP PARENT/CAMP AGREEMENT

I grant permission to the REACH Summer Camp Club of Clifton, Inc. to authorize medical care for my child in an emergency.

I have read and understand the Information Sheet and Program Guide and agree to abide by REACH Summer Camp policies and procedures in order for my child to participate in the summer program.

I understand that no refunds will be given for missed days at Summer Camp INCLUDING TRIPS.
I understand that the REACH Summer Camp fee is non-refundable.

I believe my child to be in good health and has my permission to participate in all recognized Camp activities. Unless specified above, my child has my permission to participate in any regular Camp trips that will include activities off of Camp property (daily park trips, scheduled outings and special events). I have listed all warnings and restrictions.

I grant the REACH Summer Camp my permission to use photographs, slides, and/or videotapes taken of my child while participating at the Camp in future brochures, newsletters, and visual-audio presentations, and other forms of legitimate Camp promotion, provided no identifications are made in those promotions.

In consideration of the permission and privilege of my child to participate in reasonable and normal Camp activities, I hereby agree to indemnify and save and hold harmless REACH Summer Camp, its staff and volunteers from all and any losses, claims or actions of any kind or nature that may arise from any act, omission, event or incident of any nature, occurring while my child is engaged in all reasonable and normal activities sponsored by the REACH Summer Camp.

NJ STATE LAW AND CAMP REQUIREMENT:
If your child is not enrolled as a REACH Academy student, attach a copy of camper's immunization record to the application. Your application will not be accepted without it.

4CS RECIPIENTS:
Attach a copy of your 4Cs agreement listing summer service dates (July 9th - August 17th)

HEALTH EXAMINATION FORM MUST be completed by PARENTS in order for your child to attend camp.

Parent Signature and Date: _____

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Trip Permission Slip 2018 Emergency Evacuation Permission

We (I) residing at _____ in consideration of the benefits to be gained by our (my)

child _____ , hereby consent to our (my) child's attendance and/ or participation at REACH SUMMER CAMP TRIP PROGRAM and / or in event of EMERGENCY EVACUATION from the Camp facility during the JULY 9th AUGUST 17th Summer Camp at the expense of and under the sponsorship, auspices, direction, control and jurisdiction of the REACH Summer Camp, NJ, Inc. its agents, servants and employees.

In further consideration of the benefits to be gained by our (my) child, we (I) covenant that we (I) will never, individually or as legal guardian(s) of our (my) child, institute any action at law or in equity against The REACH Summer Camp of Clifton, N.J., Inc. its agents, servants and employees, on account of any injury or other loss or damage sustained or that might be sustained by us (me) or by our (my) child as a result of our (my) child's attendance at THE SUMMER CAMP TRIP PROGRAM and /or EMERGENCY EVACUATION from the Camp facility covenant may be used by The REACH Summer Camp Club of Clifton as a defense to any action or proceeding that may be brought or instituted by us (me), our (my) heirs or legal representatives in breach of this agreement, we (I) hereby give our (my) consent, in the event all reasonable attempts to contact us (me) at:

Home _____Work _____

Cell _____Other_____

have been unsuccessful for the administration of any medical or dental treatment deemed necessary for our (my) child by any licensed physician or dentist and the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists concurring in the necessity for such surgery is obtained prior to the performance of such surgery.

The following information is needed by any hospital, physician or dentist not having access to the child history:

Allergies_____

Medications being taken_____

Date of last tetanus shot _____

Physical impairments & other important medical problem we should be aware of _____

_____

_____

If this agreement is signed by only one person, that person represents that he or she is the only person having custody of the minor child named herein and that no other person's agreement or authorization for the purposes hereof is required.

Name of Parent/Guardian _____Date _____
Name of Parent/Guardian _____ Date _____