

For office use only SCHOLARSHIP REFERRAL SOURCE \_\_\_\_\_

Received \_\_\_\_\_  
Entered into system \_\_\_\_\_  
Deposit \_\_\_\_\_  
Paid \_\_\_\_\_  
PP Sent \_\_\_\_\_

Cabin \_\_\_\_\_  
Agency \_\_\_\_\_  
Contact \_\_\_\_\_  
Called \_\_\_\_\_



# Braeside Camp



**Address:** 640 East Main Street  
Middletown, NY 10940

**Phone:** (845) 343-8985

**Fax:** (845) 698-4003

## CAMPER REGISTRATION FORM 2019

**INSTRUCTIONS:**

**THIS FORM MUST BE COMPLETED BY PARENT OR GUARDIAN AND SUBMITTED WITH PAYMENT AND OTHER REQUIRED DOCUMENTS BEFORE REGISTRATION WILL BE ACCEPTED. THE PERSON REGISTERING THIS CAMPER IS RESPONSIBLE FOR MAKING ALL PAYMENTS. PLEASE USE ONE FORM PER CHILD . Copies may be made of this form.**

Camper's Name \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Age as of 6/25/18 \_\_\_\_\_

Camper Gender: Boy \_\_\_\_\_ Girl \_\_\_\_\_

Custodial Parent / Guardian Name (First & Last Name) \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Email \_\_\_\_\_

Custodial Parent / Guardian Name (First & Last Name) \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Email \_\_\_\_\_

Camper is in the custody of: \_\_\_ Mother \_\_\_ Father \_\_\_ Both \_\_\_ Other \_\_\_\_\_

*\*If special custody arrangements exist, please provide in writing and provide documentation*

Name of Person Registering This Camper If Other Than Parent/Guardian \_\_\_\_\_

Relationship to Camper : \_\_\_\_\_

Registrant's Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Camper Emergency Contact Information**

Name: \_\_\_\_\_

Relationship to camper: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship to camper: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Camper Name : \_\_\_\_\_

**REGISTRATION INFORMATION**

- The \$50 NON-refundable deposit must remain a deposit if you are signing up for multiple weeks.  
EXAMPLE: sign up for weeks 1-3 your deposit will be used toward the last week you registered for.
- Cost: Weekly is \$200.00 for hours between 8:45 am – 5:15 pm; includes Lunch
- Extended Day: Before care available from 7:30 am & includes breakfast - \$20 per week.  
After care until 7pm & includes dinner - \$30 per week

**Overnight Camp Registration Dates**

(Please number 1, 2, 3, 4 for choice of preferred session.)

We will confirm when we receive your application as to which session you have chosen)

Start Date	End Date	Cost	Attending
1. July 1	July 12	\$650	
2. July 15	July 26	\$650	
3. July 29	August 9	\$650	
4. August 12	August 23	\$650	

\*Overnight Camp self-pay reduced rate (\$400) for income eligible Families check here \_\_\_\_\_ ( *documentation and/or letter of approval is expected at time of registration* )

**Day Camp Registration Dates**

(Check all boxes that apply)

WEEK	DAY COST (8:45 AM- 5:15 PM )	BEFORE CARE (7:30 AM – Drop Off)	AFTER CARE (7PM – Pick Up)	BOTH CARE ( 7:30AM- 7PM)
	\$200	\$220	\$230	\$250
July 1- July 5				
July 8- July 12				
July 15- July 19				
July 22- July 26				
July 29- August 2				
August 5- August 9				
August 12- August 16				
August 19- August 23				

Camper Name: \_\_\_\_\_

**Please take a moment to fill out the questions below so we may help your child adjust to camp life.**

**How did you hear about Braeside Camp?**

**What made you choose Braeside Camp this summer for your child to attend?**

**What is your child most excited about coming to camp?**

**What would be one specific goal that you would like your child to reach while here at Braeside?**

**Does your child get homesick? If so what are some suggestions you may have for our counselors in working with your child?**

**What specific suggestions do you have to make your child's transition to camp a positive one?**

**Please indicate with a check your child's current general disposition and behaviors:**

<input type="checkbox"/> Active	<input type="checkbox"/> Curious	<input type="checkbox"/> Frequently cries	<input type="checkbox"/> Easily frustrated
<input type="checkbox"/> Irritable	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Seeks constant attention	<input type="checkbox"/> Easily excitable
<input type="checkbox"/> Easy going	<input type="checkbox"/> Fears of the night	<input type="checkbox"/> Throws tantrums when angry	<input type="checkbox"/> Has difficulty w/ siblings

**What suggestions do you have for your child's counselor to assist them should a challenging moment arise?**

**What makes your child:**

**Happy**

**Sad**

**Have there been any changes in your household in the last 12 months that may affect your child's participation in camp this summer?**

Camper Name: \_\_\_\_\_

**Medical Information**

Physician Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**Medical Insurance**

Name of Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

**Please photo copy all insurance cards front and back and staple to this form.**

**Health Concerns: Does Participant have any of the following health concerns?**

Check all that apply:

Any injury or illness in past 6 months		ADD or ADHD	
Seizures		On Medication	
Head Injuries		Allergic to Food	
Fainting		Allergic to Insect or Bees	
Diabetes		Emotional Disturbance	
Asthma		High Blood Pressure	
Serious Operations		Dietary Restrictions	
Bed Wetting		Other	

If any boxes were checked please explain:

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**IMMUNIZATION RECORD**

**LEGAL REQUIREMENTS**

**WAIVED BECAUSE OF:**

A - PARENTS RELIGION

B- PHYSICANS CERTIFICATE

RECORD BASIC SERIES

AND BOOSTERS

Any serious illness other than above  
(please describe)

Immunization	Date of Immunization
Polio (TOPV)	
Polio (IVP after 1968)	
Measles	
Mumps	
Rubella	
M/M/R	
Tetanus	
DTP	

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Height \_\_\_\_\_

Weight \_\_\_\_\_

TB Contact \_\_\_\_\_

Skin \_\_\_\_\_

Scalp \_\_\_\_\_

Eyes \_\_\_\_\_

Camper Name: \_\_\_\_\_

<b>Medical Information</b>
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Illness	Date	Illness	Date	Illness	Date	Illness	Date	Illness	Date
Anemia		Heart Disease		Rheumatic Fever		Asthma or Allergies		Serious Injuries	
Chicken Pox's		Measles		Scarlet Fever		Ear Conditions		Tuberculin Test	
Diabetes		Mumps		Tuberculosis		Frequent Colds		Chest X-ray	
Epilepsy		Nephritis		Contact with TBC		Sore Throat			
German Measles		Pneumonia		Whooping Cough		Operations			

Ears \_\_\_\_\_      Nose \_\_\_\_\_      Throat \_\_\_\_\_      Teeth \_\_\_\_\_  
 Heart \_\_\_\_\_      Lungs \_\_\_\_\_      Spine \_\_\_\_\_      Glands \_\_\_\_\_  
 Athlete's foot \_\_\_\_\_      Constipation \_\_\_\_\_      Bed-wetter \_\_\_\_\_

General Remarks

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\_\_\_\_\_  
Physician's or Nurse's signature

\_\_\_\_\_  
Date

\*\*Be sure to provide copy of camper's immunizations

Camper Name: \_\_\_\_\_

<b>Medical Information</b>
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NAME OF CHILD: \_\_\_\_\_

If your child should become ill or injured at camp, the medical director has the following:

Tylenol	Ibuprofen	Benadryl
Aspirin	Ivy rest (for poison ivy)	Robitussin
Eye drops	Neosporin (antibiotic cream)	Throat spray/Cough drops
Vaseline/Dry skin cream	Hydrogen peroxide	Hydrocortisone cream
Ear-Dry	Bacitracin ointment	Bactine
Isopropyl alcohol	Antiseptic wipes	Calagel/Calamine lotion

This form serves as your consent for the child to self-administer the above medications if needed during camp.

If you do not want your child to have one or more of the above, please draw a line through it.

If your child has been prescribed medications, please list them below.

It is the responsibility of the parent/guardian to refill prescriptions.

All prescribed medications must meet the following criteria:

- Medications must be in their original containers.
- All medications must be labeled correctly (no damaged labels):
- Complete name of patient.
- Date prescription filled.
- Expiration date.
- Directions for use/precautions (if any)/storage (if any).
- Name and address of dispensing pharmacy.
- Name of physician prescribing medication.

Prescribed medications not following the above criteria will not be accepted by the medical director. If you have over-the-counter medications that your child takes on a regular basis, please include written authorization for the child to take such medication below or on the back of this page and ensure that the medication is in its original container and is correctly labeled.

Please note that children will not be allowed to carry any medications with them or keep them in their cabins. All medications must be checked in and locked away inside the infirmary.

PRESCRIPTIONS/OTHER MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_

**Dear Parent,**

**Braeside Camp has to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and a new law in New York State.**

**On July 22, 2003, the New York State Public Health Law (NYS PHL) was amended to include §2167 requiring overnight children's camps to distribute information about meningococcal disease and vaccination to the Parents or Guardians of all campers who attend camp for 7 or more nights. This law became effective on August 15, 2003. Braeside Camp is required to maintain a record of the following for each camper.**

- A response to receipt of meningococcal meningitis disease and vaccine information signed by the parent or guardian; AND**
- Information on the availability and cost of meningococcal meningitis vaccine (Menomune <sup>™</sup>); AND EITHER**
- A record of meningococcal meningitis immunization within the past 10 years; OR**
- An acknowledgement of meningococcal meningitis disease risks and refusal of meningococcal meningitis immunization signed by the child's Parent or Guardian.**

**Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.**

**Cases of meningitis among teens and young adults 15 to 24 years of age have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives.**

**A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States-types A, C, Y and W-135. These types account for nearly two thirds of meningitis cases among teens and young adults.**

**Information about the availability and cost of the vaccine can be obtained from your health care provider and by visiting the manufacturer's website at [www.meningitisvaccine.com](http://www.meningitisvaccine.com).**

**Please complete the Meningococcal Vaccination Response form.**

**To learn more about meningitis and the vaccine, please consult your child's physician.**

**You can also find information about the disease at the New York State Department of Health website: [WWW.HEALTH.STATE.NY.US](http://WWW.HEALTH.STATE.NY.US), and the website of the Center for Disease Control and Prevention (CDC):[WWW.CDC.GOV/NCIDOD/DBMD/DISEASEINFO](http://WWW.CDC.GOV/NCIDOD/DBMD/DISEASEINFO).**

**Sincerely,  
Braeside Camp**

# MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

**New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for seven (7) or more nights.**

**Check one box and sign below.**

**\_ My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years. Date received: \_\_\_\_\_**

**[Note: The vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3-5 years.]**

**\_ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will not obtain immunization against meningococcal meningitis disease.**

**Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent / Guardian)**

**Child's Name: \_\_\_\_\_**

**Date of Birth: \_\_\_\_\_**

**Mailing Address:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR TEMPORARILY  
SEPARATED FROM PARENTS/GUARDIANS**

I/We, the undersigned, parent(s)/guardian(s) of \_\_\_\_\_, a minor, do hereby authorize Braeside Camp as our agent to consent to any diagnostic procedure or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician and surgeon on the staff of, or engaged by, Hospital selected by Braeside Camp, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of our aforesaid agent to give specific consent to any and all such diagnosis, treatment, or hospital care which the physician in the exercise of his best judgment may deem advisable.

In consideration of the treatment to be rendered to the aforementioned minor, we do hereby release the Hospital and any physicians acting in connection or in conjunction therewith from any and all liability for failure of the parent to be specifically present and specifically consent to the treatment rendered to the aforementioned minor, so long as treatment is rendered in good faith and in the considered judgment of the physician and/or hospital as necessary and indicated under the circumstances.

This authorization shall remain effective until August 29, 2019 8:00 p.m. unless sooner revoked in writing delivered to said agent.

\_\_\_\_\_  
Camper Name (printed)

\_\_\_\_\_  
Parent/Guardian (signed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian (signed)

\_\_\_\_\_  
Date

**Lice-Free Guarantee**

Please ensure that your child comes to camp **without lice**. We recommend you check your child for lice prior to camp registration. Please verify that you do so with the following signature. We are trying to keep our camp free of infestation.

\_\_\_\_\_  
Parent/Guardian (signed)

\_\_\_\_\_  
Date

**Emergency Authorization in the Event the Parent/Guardian Cannot Be Reached**

*I hereby give permission to the medical personnel selected by Braeside Camp to order x-rays, routine tests and treatment for my child, and in the event I cannot be reached, I hereby give permission to the physician selected by Braeside Camp to hospitalize, secure proper treatment for and to order injection and /or anesthesia and/or surgery for my child as named above. This form may be photocopied for use off of property. I also give permission for routine medical care for my child by Braeside Camp.*

\_\_\_\_\_  
Parent/Guardian (signed)

\_\_\_\_\_  
Date

**Release from Liability**

*Braeside Camp may take pictures and/or videos for use as camp promotional material for the camp and/or programs and I realize that my child's likeness and/or mine may appear in this material. I give permission for my child to participate in any activities, either on or off camp property (including bus trips) for which my child may qualify under camp standards.*

*I recognize that there are inherent risks in most camp activities.*

*In case this application should be granted and said child be admitted to Braeside Camp. I do hereby individually, and on behalf of said child, agree to save the committee conducting Braeside Camp and each and every Official connected therewith, harmless as against any and all claims which either I or the said child might have because of injuries, accidents or sickness which said child might suffer while at Braeside Camp.*

\_\_\_\_\_  
Parent/Guardian (signed)

\_\_\_\_\_  
Date

