



# BOYS & GIRLS CLUB OF BOSTON



Unit of Orchard Park

## SUMMER CAMP JR STAFF 2019 APPLICATION

**\*\*JR STAFF MUST BE 13+ YEARS OF AGE\*\***

Location: Boston Rec Center, 8550 Boston State Road, Boston NY 14025

### CAMPER INFORMATION:

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

GENDER: \_\_\_M\_\_\_F ETHNICITY: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SCHOOL: \_\_\_\_\_ GRADE(entering in fall): \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_ ZIP CODE: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT EMAIL: \_\_\_\_\_

CHILD PRIMARILY LIVES WITH: \_\_\_ Mom \_\_\_ Dad \_\_\_ Both \_\_\_ Other

### CONTACT INFORMATION: PERSON(S) AUTHORIZED TO PICK UP CHILD:

FATHER: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ WORK#: \_\_\_\_\_ CELL#: \_\_\_\_\_

MOTHER: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ WORK#: \_\_\_\_\_ CELL#: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE #: \_\_\_\_\_ CELL#: \_\_\_\_\_

ADDITIONAL PERSON: \_\_\_\_\_ PHONE #: \_\_\_\_\_ CELL#: \_\_\_\_\_

WHICH NUMBER & PERSON SHOULD BE CONTACTED FIRST? \_\_\_\_\_

### CAMP HOURS:

**Summer Camp Hours: 7:00AM - 6:00PM (Structured day 9AM- 4:30PM)**

**Extended Hours (no charge), please check if interested: Morning 7AM - 9AM  Evening 4:30PM - 6PM**

### FEES, BILLING & CAMP DATES:

**Fee:** \$65/week - field trips are extra

**Payment:** Fees are payable by check, money order, **no cash**. To pay by credit, an invoice will be sent to you to pay online. We cannot keep credit card numbers on file. To set up weekly invoices, please contact Maura. Payment must be received each week the first day your child attends.

**Billing:** You will be billed weekly, **payment will be expected before child attends for the week**. The first bill will be mailed to you at home, after that they'll be left on the front desk in a file.

### Please check the session(s) and circle the days your child will be participating in:

___Session 1: June 24-28	M T W T F	___Session 6: July 29-Aug 2	M T W T F
___Session 2: July 1-3, 5	M T W F	___Session 7: Aug 5-9	M T W T F
___Session 3: July 8-12	M T W T F	___Session 8: August 12 - 16	M T W T F
___Session 4: July 15-19	M T W T F	___Session 9: August 19-23	M T W T F

**CAMPER HEALTH HISTORY:**

Doctor Name: \_\_\_\_\_ Doctor Phone: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

The following information must be completed by parent/guardian. Please provide as much information as possible about your child to allow our camp staff to provide appropriate care.

**Allergies** **Describe reaction &/or management of the reaction**

- Medication (e.g., penicillin) \_\_\_\_\_
- Food (e.g., eggs, dairy, peanuts) \_\_\_\_\_
- Other (e.g., insect stings, hay fever) \_\_\_\_\_

**Medications** – Medication require a separate form. Please contact the Boys & Girls Club for the form.

**Immunization History - Attach a copy of child's immunization records and list the month/day/year administered below.**

DPT Series	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	___/___/___	___/___/___
Tetanus/Diphtheria	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	or measles	___/___/___	___/___/___
Tetanus	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	or mumps	___/___/___	___/___/___
Polio OPV (Sabin)	___/___/___	___/___/___	___/___/___	___/___/___			or rubella	___/___/___	___/___/___
HIB Vaccine	___/___/___	___/___/___	___/___/___	___/___/___			Varicella	___/___/___	___/___/___
Hepatitis B	___/___/___	___/___/___	___/___/___				TB Mantoux Test	___/___/___	
Haemophilus Influenza B	___/___/___						TB Test Results	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative

**General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below:**

Has/does the camper:

- |   |  |                                     |  |
|---|--|-------------------------------------|--|
| 1. Ever been hospitalized                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Had headaches?                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Have diabetes?                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses?            | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had seizures?                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease?             | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Had fainting or dizziness?      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Ever had back/joint problems?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath      | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Have any skin problems?         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Passed out/had chest pain during exercise?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Dizzy/passed out after physical |  |
| 8. Have any nutritional or specific diet needs? | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                     |  |

Please explain any "Yes" answers: \_\_\_\_\_

Any additional information about the participant's behavior and physical, emotional or mental health the camp should be aware of: \_\_\_\_\_

**Yes**  **No** THE ABOVE INFORMATION IS ACCURATE AND CORRECT AND MY CHILD HAS HAD A PHYSICAL EXAM IN THE PAST 12 MONTHS BY A PHYSICIAN. IN THE EVENT THE CLUB IS UNABLE TO LOCATE THE PARENT(S) or EMERGENCY CONTACT, THE CLUB STAFF MAY TAKE NECESSARY EMERGENCY MEASURES. I HEREBY RELEASE THE BOYS & GIRLS CLUB OF ORCHARD PARK, ITS EMPLOYEES, ASSOCIATES, AND CONTRIBUTORS FROM LIABILITY FROM ANY INJURY, LOSS OR THEFT INCURRED BY MY CHILD WHILE PARTICIPATING. FURTHERMORE, I HEREBY AUTHORIZE MEDICAL EXAMINATION AND EMERGENCY TREATMENT FOR MY CHILD BY A QUALIFIED, LICENSED PHYSICIAN IN THE EVENT OF AN ACCIDENT.

**Yes**  **No** I GIVE PERMISSION FOR MY CHILD'S PICTURE TO BE USED IN ANY BOYS & GIRLS CLUB PUBLICATION.

**Yes**  **No** AN INVOICE WILL BE MAILED TO YOU BEFORE CAMP BEGINS. THE PARENT/GUARDIAN THAT SIGNS THIS FORM WILL BE THE PERSON RESPONSIBLE FOR THE PAYMENT, NO THIRD PARTY BILLING WILL BE OFFERED.

**MY SIGNATURE INDICATES THAT I COMPLETELY UNDERSTAND THE ABOVE STATEMENTS.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Please return application with immunization record to: [mwellington@bgclubop.org](mailto:mwellington@bgclubop.org) or mail: Boys & Girls Club of Orchard Park, PO Box 181, Orchard Park, NY 14127. PLEASE NO FAXES

**\*\*\*PLEASE NOTE: If you'd like to pay by credit card, you need to set it up with Maura. We can no longer enter credit cards in manually, you can swipe your card, or email you an invoice to pay online. Please call the Club or email Maura [mwellington@bgclubop.org](mailto:mwellington@bgclubop.org) to get set up or for more information\*\*\***

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