

Summer: JCYS Lillian L. Lutz Recreation Center • 1195 Half Day Road, Highland Park, IL 60035 • 847-432-6355
Winter: JCYS Lutz Family Center • 800 Clavey Road, Highland Park, IL 60035 • (p) 847-433-6001 x102 (f) 847-433-6003
 Rosenblatt@jcys.org www.jcys.org



2019 JCYS CHAMP CAMP REGISTRATION

Please complete one form per child.

Child's Name: _____ M/F: _____ Date of Birth _____
 Address: _____ City: _____ Phone _____
 What grade will your child be in **NEXT fall**? _____ School: _____
 Parent/Guardian 1: _____ Employer: _____
 Cell Phone: (____) _____ Work #: (____) _____
 Parent/Guardian 2: _____ Employer: _____
 Cell Phone: (____) _____ Work #: (____) _____
 Email #1: _____ #2 _____

T-shirt size: Youth S M L Adult S M L XL

- Please register my child for Champ Camp: M-F 6/17-7/19 (no camp 7/4) 12:15-3:30
 Cost: \$850: (\$85 non-refundable deposit required; balance due by 5/1, 2019)
- If you would like to apply for scholarship, please complete attached form
- Special for all JCYS campers:** Check if you'd like to add \$100 to your tuition for a **2019 Family Membership** at the JCYS Lillian L. Lutz Recreation Center (\$180 value!!)



\$85 non-refundable deposit due at the time of registration. Add \$100 for a Lil' Family Pass.

Please include a check payable to JCYS or cash. Please note: JCYS does not accept credit cards.

Signature: _____ Date: _____

****ATTENTION: Next page must be complete****

Parent or Guardian Consent

1. I understand that the registration fee as listed must accompany this form and that it is non-refundable and non-transferable unless the child is not accepted into the program. I further understand that as the parent/guardian registering the above-named child, I alone, am responsible for the fees.
2. I understand that enrollment is contingent upon all payments being current.
3. I understand that there is no reduction in fees made for illness, vacations or holidays/closings.
4. I understand that fees may be subject to change given 60 days notice.
5. I understand that a medical form must be filled out, signed and returned before the first day of camp. Should my child have severe allergies or any other medical condition, a Medical Emergency Action Plan and Risk and Waiver Agreement must also be signed and returned before the first day of camp.
6. I understand that because JCYS makes commitments to its teaching staff based on registrations received, there will be no refunds for registration fees or tuition payments.
7. I understand that in the event that JCYS determines that the continued participation in the camp program is not appropriate; JCYS reserves the right to discontinue service.
8. I give permission for any member of my family to be included in promotional pictures or videos that may be used in variety of media, including but not limited to: JCYS brochures, advertisements, website, and social media outlets such as Facebook and Twitter.
9. I understand that the Jewish Council for Youth Services is not responsible for personal property.
10. In the event of an emergency, if the Camp or After Camp Care staff cannot reach me or emergency contacts named, I authorize the JCYS Director to act for me according to his/her best judgment.
11. In the event that I or the emergency contacts named cannot be reached involving my child, I hereby give permission to the appropriate medical personnel selected by the JCYS Director, to provide medical treatment deemed necessary by such medical personnel, including x-rays, tests, injections, hospitalization, anesthesia and surgery.

I have read and fully understand the above policies and agree to abide by them.

Parent/Guardian Signature: _____ Date: _____

EMERGENCY INFORMATION:

ALLERGIES/MEDICAL CONDITIONS: _____

Needs (circle all that apply): Epi-Pen Inhaler Diabetes testing/medication Other: _____

Emergency Contacts/Authorized Pick-Ups:

Name: _____

Name: _____

Phone: _____

Phone: _____

Cell: _____

Cell: _____

City: _____

City: _____

Relationship: _____

Relationship: _____

Transportation Permission

Please sign below to give us permission to transport your child to an alternate location if the weather is dangerously hot. On these days, pick up will be at The Lil' as usual.

Parent Signature

Date



JCYS JON VEGOSEN CHAMP CAMP 2019 CAMPER INTAKE FORM



Name of camper _____ Boy _____ Girl _____ D.O.B. _____

This summer will be your child's: 1st ___ 2nd ___ 3rd ___ 4th ___ 5th ___ 6th ___ summer at camp.

How does your child feel about attending camp _____

Does your child have any fears that we should know about?

_____ We want your child's experience at Champ Camp to be the best. Please let us know if your child has any difficulty in any of the following areas and indicate if you'd like us to contact you to discuss ways to best support your child. Please check if your child has difficulty:

- | | |
|------------------------------|----------------|
| _____ Learning new things | Comment: _____ |
| _____ Making friends | Comment: _____ |
| _____ Following rules | Comment: _____ |
| _____ Maintaining attention | Comment: _____ |
| _____ Playing sports | Comment: _____ |
| _____ Other (please specify) | Comment: _____ |

Please list any special services your child receives at school (i.e.: special classes, social work, tutors, etc.)

Please list any allergies your child has: _____

Please indicate any medication your child takes during the school year: _____

Will your child continue to take this medication during the summer? Yes _____ No _____

Please explain any medical or emotional condition that may impact your child's ability to participate:

Marital status: Married _____ Divorced _____ Separated _____ Single Parent _____
Widow _____

Have there been any significant changes in your child's life (i.e.: divorce, death of a family member, move, new school, new baby, etc.)?

_____ The information provided above is true to the best of my knowledge.

Parent Signature _____ Date _____

Health History Form for Children, Youth and Adults Attending Camps FM 11

Suggested for Day Camp Use

Developed and approved by
American Camp Association
with the American Academy of Pediatrics
Expires 10/01/06

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon

Dates of Camp Attendance _____

Mail this form to the address below by _____ (date)

participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Year

Name _____ Birth date _____ Age at camp _____
Last First Middle

Home address _____
Street Address City State Zip

Social security number of participant _____ Gender: Male Female

Custodial parent/guardian _____ Phone _____

Home address (if different from above) _____
Street Address City State Zip

Business address _____
Street Address City State Zip Phone _____

Second parent or guardian or emergency contact _____

Address _____ Phone _____
Street Address City State Zip

Business address _____ Phone _____
Street Address City State Zip

If not available in an emergency, notify _____

Relationship _____ Phone _____

Address _____
Street Address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____

► Photocopy of front and back of health insurance card must be attached to this form.

Important — These boxes must be complete for attendance*

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release

Signature of parent or guardian or adult camper/staffer _____

Printed name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer _____ Date _____

**If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies (list)

Food allergies (list)

Other allergies (list) — include insect stings, hay fever, asthma, animal dander, etc.

Session or Group

Name

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing

physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person **takes NO medications** on a routine basis. OR This person **takes medications** as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____
 Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____
 Reason for taking _____

Attach additional pages for more medications.
 Identify any medications taken during the school year that participant does/may not take during the summer _____

RESTRICTIONS (The following restrictions apply to this individual.)

Does not eat: Red meat Pork Dairy products Poultry Seafood Eggs Other (describe) _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary) _____

GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions. _____

Which of the following has the participant had?	Please give all dates of immunization for:
<input type="checkbox"/> Measles	Vaccine: Dates: Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr
<input type="checkbox"/> Chicken pox	DTP _____
<input type="checkbox"/> German measles	TD (tetanus/diphtheria) _____
<input type="checkbox"/> Mumps	Tetanus _____
<input type="checkbox"/> Hepatitis A	Polio _____
<input type="checkbox"/> Hepatitis B	MMR _____
<input type="checkbox"/> Hepatitis C	or Measles _____
	or Mumps _____
	or Rubella _____
TB Mantoux Test	Haemophilus influenza B _____
Date of last test _____	Hepatitis B _____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (chicken pox) _____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware. _____

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Screening Record (For camp use only) _____ Screened by _____

Date screened _____ Time _____ am _____ pm Updates/additions to health history noted Yes No None required

Meds received _____

Current health needs identified _____

Observational notes _____