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
Jrosenblatt@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☐

Special Offer!
$100
Family Pass!!
(a $200 value)

☐ 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 Champ 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: _____
Phone: _____
Cell: _____
City: _____
Relationship: _____

Name: _____
Phone: _____
Cell: _____
City: _____
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 _____

REQUEST FOR FINANCIAL ASSISTANCE – CONFIDENTIAL*

JCYS Jon Vegosen Champ Camp

FAMILY INFORMATION

Camper Name(s) _____ Parent/Guardian Name _____

Address _____ City/State/Zip _____

Home Phone ( ) _____

Parent # 1 Name _____ Work Phone ( ) _____ Occupation _____

Employer _____ ( ) Full Time ( ) Part Time Hours/Week _____

Parent # 2 Name _____ Work Phone ( ) _____ Occupation _____

Employer _____ ( ) Full Time ( )Part Time Hours/Week _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Other _____

Total # of People in Household _____

Household Makeup: Check all that apply **– total must equal Total # of people in household listed above.**

___ Parents 1 or 2 __ Grandparents 1 or 2 # of children in house _____ Ages ____ ____ ____ ____

___ Others # and relationship to applicant _____

FINANCIAL INFORMATION (All information must be filled out in order for your request to be considered)

AMOUNT OF THIS YEAR'S REQUEST $ _____ (THIS LINE MUST BE FILLED IN)

Have you received Financial Assistance from JCYS previously? __No __ Yes Year ____ Amount $_____

Are you requesting Financial Assistance from any other JCYS program this year? __No __Yes

Total # of Years with JCYS _____

ANNUAL INCOME - (Do not omit any items; fill in an amount, $0. or N/A (not applicable).

	1/1 – 12/31 2018		Estimated 1/1 – 12/31 2019	
	PARENT #1	**PARENT #2**	**PARENT #1**	**PARENT #2**
Gross Wages from Employment	$ _____	$ _____	$ _____	$ _____
Bonus/Commissions	$ _____	$ _____	$ _____	$ _____
Unemployment Compensation	$ _____	$ _____	$ _____	$ _____
Child Support	$ _____	$ _____	$ _____	$ _____
Soc.Security Benefits	$ _____	$ _____	$ _____	$ _____
Interest/Dividends	$ _____	$ _____	$ _____	$ _____
Alimony/Maintenance	$ _____	$ _____	$ _____	$ _____
Disability Benefits	$ _____	$ _____	$ _____	$ _____

List income from any other sources. Include amount from each source (i.e.: rentals, business, grandparent's assistance, etc. .)

PLEASE EXPLAIN THE FAMILY/FINANCIAL SITUATION THAT MAKES IT DIFFICULT FOR YOU TO PAY THE FULL PROGRAM FEE. PLEASE BE SPECIFIC. THIS STATEMENT IS A CRITICAL PART OF THE COMMITTEE'S REVIEW PROCESS. THE MORE DETAILED YOU ARE, THE BETTER THE COMMITTEE CAN ADDRESS YOUR NEED. **IF YOU RECEIVED SCHOLARSHIP LAST YEAR OR THIS YEAR PLEASE NOTE ANY SIGNIFICANT CHANGES IN INCOME OR FAMILY SITUATION FROM PRIOR OR CURRENT YEAR.**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name of Party Responsible for Payment _____ Phone # ( ) _____

Relationship to Camper _____

I have checked this application and affirm that the information provided is complete and accurate. I understand that if I am awarded a scholarship, false statements, omissions or misrepresentations on this form may result in revocation of the entire scholarship amount.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Person Responsible for Payment Date

PLEASE PROVIDE A COPY OF YOUR FEDERAL TAX FORMS INCLUDING FORM 1040 AND ANY APPROPRIATE SCHEDULES.

***The names of scholarship recipients and the amount of assistance will be reported to the IRS on the JCYS 990 and become part of a public record IF the scholarship is awarded to a current/former officer, director, key employee, substantial contributor or related person.**

(SR 6/2013)

For Office Use

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

Dates of Camp Attendance _____

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

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

Year

Session or Group

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 _____ Phone _____
Street Address City State Zip

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.

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 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.

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.

_____ _____

_____ _____

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
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever passed out during or after exercise?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐
14. Ever had high blood pressure?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐
16. Ever had back problems?	☐	☐
17. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
18. Have an orthodontic appliance being brought to camp?	☐	☐
19. Have any skin problems (e.g., itching, rash, acne)?	☐	☐
20. Have diabetes?	☐	☐
21. Have asthma?	☐	☐
22. Had mononucleosis in the past 12 months?	☐	☐
23. Had problems with diarrhea/constipation?	☐	☐
24. Have problems with sleepwalking?	☐	☐
25. If female, have an abnormal menstrual history?	☐	☐
26. Have a history of bed-wetting?	☐	☐
27. Ever had an eating disorder?	☐	☐
28. Ever had emotional difficulties for which professional help was sought?	☐	☐

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

_____

Which of the following has the participant had?

- ☐ Measles
- ☐ Chicken pox
- ☐ German measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

TB Mantoux Test

Date of last test _____

Result: ☐ Positive ☐ Negative

Please give all dates of immunization for:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP						
TD (tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Haemophilus influenza B						
Hepatitis B						
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_____