

Dear Parents,

There may be snow on the ground, but it is never too early to start thinking about Putnam Valley Day Camp! Again this year for your convenience, we will be offering some Saturdays registration dates with special discounts @ PV Parks and Recreation from 9:00 AM-12:00 PM. Registrations will also be accepted Monday through Friday, 8 AM-4 PM @ the Recreation Office. ALL REGISTRATIONS MUST BE COMPLETE OR YOU WILL BE TURNED AWAY! Please note that in the application packet is a Medical Evaluation that must be completed by your child's physician (a computer print out is appropriate from the Doctor too)-the child's physical must be within one year by the opening of camp. If expiring, please submit date of physical examination.

The Saturday registration dates are as follows: Saturday **March 26**, Saturday **April 2**, Saturday **April 16**, Saturday **May 7**, and Saturday **May 21**.

By registering at one of our Saturday registration dates, you will save \$20 per week or \$25 per week if registering for all 8 weeks! We will not offer this at any other time-ONLY ON THE SATURDAY DATES LISTED ABOVE.

The Day Camp Fees for the Summer 2011 season are as follows:

<p style="text-align: center;">2011 PUTNAM VALLEY DAY CAMP FEES Register before 4/07/11: \$1,350 for all 8 weeks or \$200/wk Register before 5/22/11: \$1,450 for all 8 weeks or \$220/wk Register after 5/22/11: \$1,500 for all 8 weeks or \$235/wk</p>

We are also reminding parents who wish to add any additional weeks of enrollment during the camp season, **that the arrangements must be made by the Friday prior to the week they will be adding-PAYMENT IN FULL IS EXPECTED AT THIS TIME.** It has proven to be difficult to accommodate new campers on short notice. Parks & Recreation and our day camp administrative staff will be steadfast about this. All additional weeks must be secured at Parks and Recreation Office-not at Day Camp.

New this year-the Teen Travel program WILL NOT be accepting any campers the week of a trip. All Teen Travel reservations must be made by the Friday prior to the trip. No exceptions will be made to this new procedure.

Downloadable versions of our day camp applications are available at www.pypr.com. Please register for our bulk email list while on the Parks and Recreation website. This will enable you to keep up with all of the camp's updates and notifications. This is our first stride toward a paper-free program and hope to have you all participate. Paper copies are still available in the Parks & Recreation office.

Registration Materials Check-List

To assist us in providing a fun, safe Summer Program experience for your child, please provide the following materials to register:

- Registration packet complete
- Recent school picture
- Recent physical signed by personal physician
- Immunization record
- Self-administered medication permission form
- Allergies/health condition form completed
- Restricted pickup (if applicable)
- 4 Digit PIN Number
- 2 Emergency Contacts
- Consent for medical care
- Consent to travel off premises (grades 6-10)
- Photo authorization
- Swimming lessons (if applicable)
- Parent handbook sign-off
- Medical Sheets to be Completed by Physician

**REGISTRATION PACKETS WILL NOT BE
ACCEPTED UNLESS THEY ARE COMPLETE!**

Putnam Valley Parks & Rec.

Day Camp Registration

Summer 2011



Please
Affix
Color
Photo
Here

Participant Information

Name: _____
4 Digit PIN #: _____
 Date of Birth: ____/____/____ Age: ____
 Grade Starting 9/2011: _____

Parent/Guardian Contact - First

Name: _____ Relationship: _____
 Street Address: _____
 Town/City: _____ Zip Code: _____
 Mailing Address (if different than above): _____
 Phone Contact: Cell #: ____ - ____ - ____ Work #: ____ - ____ - ____ Home #: ____ - ____ - ____

Parent/Guardian Contact - Second

Name: _____ Relationship: _____
 Street Address: _____
 Town/City: _____ Zip Code: _____
 Mailing Address (if different than above): _____
 Phone Contact: Cell #: ____ - ____ - ____ Work #: ____ - ____ - ____ Home #: ____ - ____ - ____

Program Selection

Please place an X in the box below indicating the program(s) and session(s) you are registering your child for:

Session Program	1 6/27 - 7/1	2 7/5 - 7/8	3 7/11 - 7/15	4 7/18 - 7/22	5 7/25 - 7/29	6 8/1 - 8/5	7 8/8 - 8/12	8 8/15 - 8/19	Total #Wks	Fee
Day Camp										
Before Care										
After Care										
Total										

Day Camp Fee

Register before 4/7/10: \$1,350 for all 8 weeks or \$200/wk
 Register before 5/22/10: \$1,450 for all 8 weeks or \$220/wk
 Register after 5/22/10: \$1,500 for all 8 weeks or \$230/wk

Children's Center Fee

Before Care: \$30 per week
 After Care: \$55 per week

Restricted Pick-Up

If there is anyone who you **do not authorize** to pick-up your child, please list here:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

(If the person listed is the child's parent, a copy of the court document terminating parental rights must accompany this request.)

Emergency Contact #1 (must be someone other than parent/guardian)

Name: _____ Relationship: _____

Street Address: _____

Town/City: _____ Zip Code: _____

Phone Contact Order of Preference: #1 ____ - ____ - ____ #2 ____ - ____ - ____ #3 ____ - ____ - ____

Emergency Contact #2 (must be someone other than parent/guardian)

Name: _____ Relationship: _____

Street Address: _____

Town/City: _____ Zip Code: _____

Phone Contact Order of Preference: #1 ____ - ____ - ____ #2 ____ - ____ - ____ #3 ____ - ____ - ____

Personal Physician

Name: _____ Phone: _____

Personal Dentist

Name: _____ Phone: _____

Participant Medical Information

Health History

Does your child experience frequent:

<u>Y</u>	<u>N</u>	<u>Condition</u>	<u>When</u>	<u>Details</u>
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Back/Joint Pain	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bonded Teeth	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Concussion	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Contacts/Glasses	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dentures	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dizzy Spells	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Emotional Disorder	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eye Infections	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heat Related Illness	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hernia	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Infectious Disease	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mumps	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Orthodontia	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Recent Exposure to Contagious Disease	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Recent Exposure to Lice	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disorder	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Skin Condition	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Surgery	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Throat Infections	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer/Gastric Disorder	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infections	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Infections	_____	_____

Activity or Dietary Limitations/Restrictions

Please note any activity or dietary limitations/restrictions while at Summer Program:

Please list any medications your child has taken in the last 6 months that he/she will NOT be taking over the summer:

Medical Emergency Action Plan

In the event of a medical emergency Summer Program Medical Personnel will assess your Child. If your Child requires advanced emergency medical care, Putnam 911 will be called to request an ambulance. If your Child requires hospital care, he/she will be transported by ambulance to the nearest appropriate hospital. A Summer Program Staff Member will accompany your Child.

You will be notified as soon as your Child has been evaluated by Summer Program Medical Personnel. We will contact the Parents/Guardians in the order listed on the summer Program Registration form.

#1. Medical Condition Requiring Special Medical Action Plan:

Name of Medical Condition: _____

Potential Reaction: _____

Medical Care Required*: _____

* If medication is required, please be sure to complete the Physician Authorization for Supervised Child Self-Administered Medication form attached.

#2. Medical Condition Requiring Special Medical Action Plan:

Name of Medical Condition: _____

Potential Reaction: _____

Medical Care Required*: _____

* If medication is required, please be sure to complete the Physician Authorization for Supervised Child Self-Administered Medication form attached.

#3. Medical Condition Requiring Special Medical Action Plan:

Name of Medical Condition: _____

Potential Reaction: _____

Medical Care Required*: _____

*If medication is required, please be sure to complete the Physician Authorization for Supervised Child Self-Administered Medication form attached.

Medical Screening

Anaphylaxis _____ EPI Pen: yes no Asthma: yes no Inhaler: yes no

Immunizations up to date: yes no

Screened by: _____ Date: _____

Medications Received

Medication Name	Date Rcd	Date Rtn	Returned To	Parent/Guardian Initials
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

THIS PAGE DOES NOT APPLY TO MY CHILD Initial: _____

Physician Authorization for Supervised Child Self-Administered Medication

As permitted by the Putnam County Board of Health, Putnam Valley Summer Program will supervise child's self-administration of physician prescribed medication. Child self-administered medication will be supervised by our medical staff once the following conditions have been met:

- Medication is transported to Summer Program and delivered to Summer Program medical personnel (not child's counselor) by an adult only (not the child).
- All medication (including over the counter) must be brought in the **original container** and **labeled with:**
 - Complete name of patient
 - Date prescription was filled (not applicable to over the counter medication)
 - Expiration date
 - Specific directions for use
 - Name and address of dispensing pharmacy (not applicable to over the counter medication)
 - Name and phone number of prescribing health care provider

I hereby give permission for my child _____ to receive the medication listed below as prescribed by my child's personal physician. I understand that this medication will be self-administered under the supervision of the Summer Program's medical staff.

Medication: _____
Dosage: _____
Special Instructions: _____
Time to be Self Administered: _____
Side Effects: _____

Summer Program Staff should notify the following physician _____
at the following phone number ____ - ____ - ____ if the following side effects occur:

Parent/Guardian Signature
(This signature is authorization for both parents or guardians)

Physician's Signature

Parent's Name (Print)

Physician's Name (Print)

Date

Date

THIS PAGE DOES NOT APPLY TO MY CHILD Initial: _____

Medication Administered at Home

My child is currently taking the following medication at home: _____

This medication does not need to be taken during program hours or at the Before/After Care program.

The following are possible side effects to taking this medication (i.e.; sun sensitivity, hyperactivity, excessive thirst, feeling tired, etc.):

Notify the following physician _____ at the following phone number _____ - _____ - _____ if the following occurs: _____

Print Name of Parent/Guardian

Signature of Parent/Guardian
(This signature is authorization for both parents/guardians)

Date

THIS DOES NOT APPLY TO MY CHILD Initial: _____

Potassium Iodide Opt-Out Form

In the event of a nuclear incident, I **DO NOT** want Potassium Iodide (KI) administered to my child.

I have read the attached information sheet on Potassium Iodide (KI) and understand the benefits and risks of administering Potassium Iodide (KI) in the event of a nuclear incident.

I consent that Potassium Iodide **SHOULD NOT** be given to my child.

Child's Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature:
(This signature is authorization for both parent's/guardian's)

Date:

MEDICAL EVALUATION

(To be completed by physician)

Name _____ Date of Birth _____ has had a complete history and physical exam on _____
Month/Day/Year Month/Day/Year

Screening / Test Results

Height:	BMI:	Vision/Type of Screening
Weight:	<input type="checkbox"/> Normal	With Glasses R 20 / L 20 /
Blood Pressure:	<input type="checkbox"/> Abnormal	With out Glasses R 20 / L 20 /
Pulse:	Min:	
HCT/Hgb:	Slight:	Auditory /Type of Screening
Urinalysis:	Mod:	Right Pass / Fail
Gross Dental:	Marked:	Left Pass / Fail
Lead (Date/Result):	<input type="checkbox"/> Referral to:	

TB: In high-risk group? <input type="checkbox"/> yes <input type="checkbox"/> no TB & other Test Results: (Sickle Cell, etc.)		
Test	Date	Result

Disease Assessment

Yes No		Date of Onset
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Exercise Induced <input type="checkbox"/> unclassified	
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> Type I <input type="checkbox"/> Type II	
<input type="checkbox"/> <input type="checkbox"/> Anaphylactic Reaction	<input type="checkbox"/> Food <input type="checkbox"/> Insect <input type="checkbox"/> Latex <input type="checkbox"/> Other: Explain	
<input type="checkbox"/> <input type="checkbox"/> Seizure Disorder	Type:	
<input type="checkbox"/> <input type="checkbox"/> Chicken Pox	If yes, when?	
<input type="checkbox"/> <input type="checkbox"/> Mumps	If yes, when?	
<input type="checkbox"/> <input type="checkbox"/> Other: Please Specify		

Immunization History

(Please provide month, day and year of immunization)

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DPT / Hib						
DTaP						
DT / Td						
OPV						
IPV						
MMR						
HiB						
Hep B						
Hep A						
Varicella						
TDap						
PCV						
HPV						
MCV						
Influenza						

Prescription Medication: Please complete with patient's current regimen for both scheduled and PRN medications including heparin flushes for central lines; please use additional paper if needed.

DRUG	ROUTE	DOSAGE	FREQUENCY	COMMENTS
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Individualized Orders: The following Standard “Over the Counter / PRN Medications “ are available in the Health Center to be administered if needed per the family physician’s instructions.

***** THIS SECTION MUST BE COMPLETED *****

Drug Name (Generic equivalents may be used)	Dosage	Route	Indications	Healthcare Provider Permission	Comments
Diphenhydramine	As per pkg by wt. & age	PO	Allergies or Allergic Reactions	Yes / No	
Burn Gel	Apply to minor burns	Topically	Minor Burns	Yes / No	
Stool Softner	As per pkg by wt. & age	PO	No BM x 3 Days	Yes / No	
Acetaminophen	As per pkg by wt. & age	PO	Temp. ≥ 100°F or Pain	Yes / No	
Ibuprofen	As per pkg by wt. & age	PO	Temp. ≥ 100°F or Pain	Yes / No	
Hydrocortisone	Apply to effected area 3x/day	Topically	Itch	Yes / No	
Cough Drops	As per pkg by wt. & age	PO	Cough or Sore Throat	Yes / No	
Antacid	As per pkg by wt. & age	PO	Upset Stomach	Yes / No	
Antibiotic Oint.	Apply to effected area 3x/day	Topical	Scrapes or Cuts	Yes / No	

This form is not exhaustive or restrictive. It is meant by the Putnam County Health Department only as a guide.

Please note, *if the provider has not circled yes, it means no.* Following the above without the provider’s explicit direction is practicing medicine without a license.

Emergency Medications:

Does this person require: Epi-pen: yes no PRN Inhaler: yes no
 This person has permission to carry: Epi-pen: yes no PRN Inhaler: yes no
 (Note: ability to carry implies ability to self administer)

Additional Orders: As deemed necessary by health care provider to be implemented by an R.N. (i.e. peak flows, blood draws/lab work, dressing changes, cast care, feeds via GT, etc.): _____

Limitations on Activities:

Swimming _____ Diving _____ Hiking _____ Athletics _____ Other: _____

Explain above: _____

HIPPA Privacy Statement: Permission to Release Confidential Health Information

I give _____ permission to release confidential health information to
Name of Medical Practice

_____ regarding this person _____
Name of Camp Name of Camper or staff member Date:

Parents/Guardian Signature: _____

I certify that I have on this date examined the above named camper and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this camper to participate in physically strenuous activities.

Signature of Physician _____ Date of Examination _____

Please Print: Physician’s Name _____ License# _____

Address _____ Phone# _____

Parents Signature: _____ Date: _____

Putnam Valley Summer Programs 2011 Authorization Form

Program Participation

I hereby give permission for my child to participate in all activities conducted at the Town of Putnam Valley Recreation Department's Day Camp, and/or Children's Center and/or Travel Teen Center (hereby referred to as a Summer Program) for which they are registered and age qualified, unless previously noted in this packet. I understand that there is a risk of injury to a child participating in these activities and I hereby assume the risk of permitting my child to participate in such activities. I understand that the Town of Putnam Valley does not have accident Insurance.

In consideration of the Summer Program's acceptance of my child and to the extent permitted by law, I hereby agree to release and hold harmless, the Town of Putnam Valley, its officers, employees, and volunteers from any and all responsibility, liability, claims, and/or demands arising out of the participation of my child in Summer Program, specifically including any injury that may occur due to the negligence of the Summer Program. I hereby specifically agree that any action arising out of the participation of my child in Summer Program shall be brought exclusively in the State Courts within the County of Putnam. I hereby waive any and all rights to remove or transfer any such action of the State Courts within the County of Putnam.

I understand that I must pay all fees regarding Summer Program, prior to the beginning of Summer Program.

If my child is registered for Day Camp, I understand that Day Camp drop-off is at 9:00 a.m. and pick-up is at 4:00 p.m., unless other arrangements have been made with the Children's Center Before and After Camp program. I understand that I will be charged an additional fee if I drop-off my child prior to or pick-up after the regularly scheduled time indicated above.

I have read and understand the Putnam Valley Parks & Recreation Department's Registration and Policies Statements.

I have read the Putnam Valley Day Camp 2011 Guide and the Parent Manual, and/or the Children's Center Guidelines and/or the Travel Teen Center guidelines, and understand and agree to abide by the rules and regulations, and any restrictions placed on the participation of my child in activities at Summer Programs. I understand further that if my child or I fail to abide by such rules, regulations or restrictions, my child may not be allowed to participate in activities at Summer Program with no refund of Summer Programs fees.

Signature of Parent/Guardian

Date

(This signature is authorization for both parents/guardians)

Consent for Medical Care

I understand that if my child needs medication during Summer Program, including over the counter medication, I will secure a prescription for that medication from my child's health care provider. I also understand the medication will be self-administered by the child, under the supervision of the Health Director or Health Staff.

I hereby give my permission to the Summer Program to provide first aid care, assist in child self-administered prescribed medication, to seek emergency medical treatment and to arrange necessary medical transportation. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Summer Programs to secure and administer emergency medical treatment, including hospitalization. I agree to the release of any Summer Program records necessary for insurance purposes.

Signature of Parent/Guardian

Date

(This signature is authorization for both parents/guardians)

Consent to Travel off Premises (Grades 6-10)

I hereby **give my consent** for my child to travel off premises with the Putnam Valley Summer Program for any activity I have been previously notified about. I acknowledge that my child will be transported by bus. I also give permission to my child to be involved in swimming activities that may occur off the premises with the proper supervision. If I add a week for my camper that has a trip and the trip has already been filled, my camper will NOT be permitted to attend camp for that day.

Signature of Parent/Guardian

Date

(This signature is authorization for both parents/guardians)

Photo Authorization

I hereby **consent** to the taking of photographs, movies, or videos of the child registered above by the staff or it's designated representatives. I also grant the right to edit, use and reuse said products for any and all legal purposes selected by the Summer Program and release any and all rights, title and interest we may have in such products of the same in connection with such uses.

I acknowledge that the information I have provided is accurate to the best of my knowledge. I agree to notify the Putnam Valley Summer Program immediately of any changes to this information.

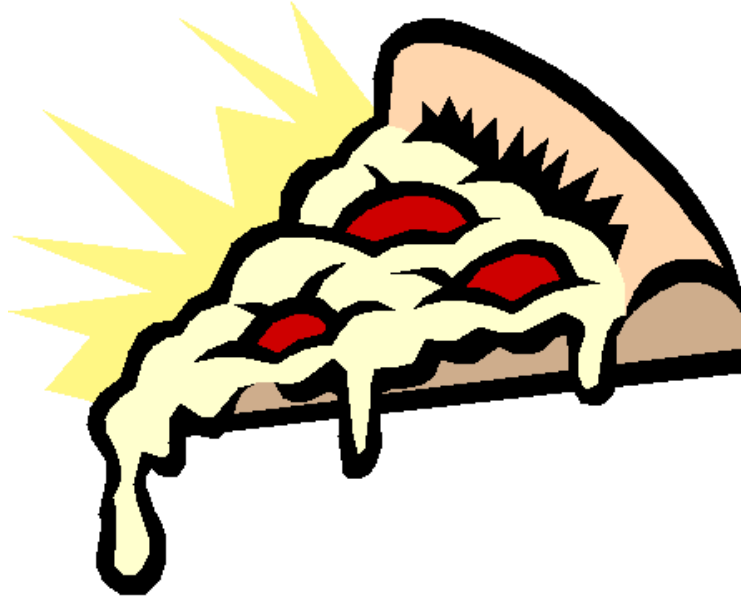
I do **NOT** want pictures taken with my child in them

Signature of Parent/Guardian

Date

(This signature is authorization for both parents/guardians)

PIZZA FRIDAYS!!!



The Putnam Valley Day Camp will be having Pizza for Lunch EVERY FRIDAY!

Provided to us by the
“Putnam Valley Market”

Cost per week:
2 Slices + Soda = \$4.00

****PIZZA MONEY IS DUE AT TIME OF REGISTRATION****

Child Name _____

Drink Choice (circle one): Coke Sprite Water

Week (Circle all that apply): 1 2 3 4 5 6 7 8
