



Youth Services

2010 Summer Camp

The Ultimate Experience

July 5 - August 27

OFFICE USE ONLY

Keswick Week _____

Sutton Week _____

Phone: 905.722.5540

Fax: 905.722.4308

Email: jerichoys@sympatico.ca

REGISTRATION FORM

Day Camper Information

Camper Name: _____

Address: _____

City/Town: _____ Province: _____

Postal Code: _____ Phone: _____

Email: _____ Birth Date: _____

Age at Camp: _____ Male: _____ Female: _____

Are you a returning camper?: Yes / No (please circle one)

How did you hear about Jericho Youth Services *The Ultimate Experience* camp?

Parent/Guardian Information

Name: _____

Relationship to Camper: _____

Address: (if different than above) _____

City/Town: _____ Province: _____

Postal Code: _____ Phone: _____

Phone (daytime): _____ Phone (cell): _____

Alternate Contact (required)

Name: _____

Relationship to Camper: _____

Address: _____

City/Town: _____ Province: _____

Postal Code: _____ Phone: _____

Phone (daytime): _____ Phone (cell): _____

NOTE: An Inclusion Facilitator is available for campers who may require one to one assistance at camp. For more information on this free service please check "yes". A representative from JYS will contact you. Yes, I'm interested in more information No, I'm not interested



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Registration Information (Day Camp runs Monday to Friday)

I want to register for the following weeks of day camp:
(\$115.00 / 5 day \$92.00 / 4 day) Before & After Care (\$15/week each)

Week	Dates	Keswick Camp	Sutton Camp	Before Care (\$15.00)	After Care (\$15.00)	Total
1	July 5-9	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
2	July 12-16	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
3	July 19-23	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
4	July 26-30	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
5	Aug 3-6 *	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
6	Aug 9-13	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
7	Aug 16-20	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
8	Aug 23-27	\$ unavailable	\$ _____	\$ _____	\$ _____	\$ _____
					Final Total:	\$ _____

Signature of Parent/Guardian

Date

- Week 5 (4 day week)

OFFICE USE ONLY

CASH \$ _____

CHEQUE _____ (sorry no post-dated cheques) Cheque payable to **Jericho Youth Services**

FUNDING / SUBSIDY _____

PAYPAL CONFIRMATION # _____

2010 SUMMER CAMP – *The Ultimate Experience*

CAMP REFUND POLICY

In order to receive a refund or registration credit, all cancellation credits for camp must be received in writing at least 5 business days prior to the first day of the camp session. No refunds or credits will be processed less than 5 business days before the start of the camp session.

A \$25.00 administrative fee will apply to all refunds.

REGISTRATION DROP OFF LOCATION

Jericho Youth Services Head Office
1964 Metro Road, Sutton
905.722.5540
Mon. – Fri. 9:00 – 3:00

Alternate Locations:

Georgina Gym
90 Wexford Drive, Keswick
905.989.0896

Mon – Fri 3:30 – 10:00

Ask for LINDSEY

Pefferlaw Youth Centre
272 Pefferlaw Road, Pefferlaw
705.437.2100

Mon – Thu 3:00 – 8:00

Ask for LAURA

Sutton Youth Centre
20894 Dalton Road, Sutton
905.953.6941

Mon – Fri 3:30 – 6:45

Ask for SAMANTHA

Information Agreement - Please read and sign

The parents/guardians having legal custody over any camper must communicate all legal and agreed arrangements. Conditions of custody, if applicable, will be communicated in writing to the camp along with a photocopy of any court order referring to visitation rights/denials.

The Camp Manager reserves the right to dismiss a camper who in his/her opinion is a hazard to the safety and rights of others, or who appears to have rejected the controls of the camp.

While every precaution is taken for the safety and good health of our campers, Jericho Youth Services, it's directors and staff members, or the employees of facilities outside of the camp grounds are hereby released from any and all liability in the event of an illness, accident, misfortune or death that may occur to the camper.

To the best of my knowledge, my child is in good health and I will notify the Camp if my child is exposed to an infectious disease during the week prior to arriving at Camp. In the case of a medical emergency, I understand that every effort will be made to contact parents or guardians. In the event that I cannot be reached, I hereby give permission to the physician selected by the Day Camp Manager, to secure proper treatment, hospitalization, for my child as named above.

Parent/Guardian Signature: _____ Date: _____

See you at Jericho Summer Camp – The Ultimate Experience

**Jericho Youth Services
Summer Camp – *The Ultimate Experience***

2010 MEDICAL EMERGENCY FORM

FORM REQUIRED FOR EVERY CAMP PARTICIPANT!

Child's Name: _____ **Home Phone #:** _____

Camp Location (Circle one): **Sutton** **Keswick**

Parent/Guardian: _____ **Contact #'s:** _____

Parent/Guardian: _____ **Contact #'s:** _____

Doctor's Name: _____ **Doctor's Phone #:** _____

Emergency Contact (Other than above)

Name: _____ **Phone #:** _____

Description of medical concern: (ie: seizures, diabetes, asthma, anaphylactic, etc):

Signs and Symptoms the child usually exhibits: _____

Immediate action (should be discussed with Camp Supervisor)

Follow up Action: _____

Location of Emergency Aid (i.e.: Epi-pen, sugar, etc)

If your child has medication at camp, a Jericho Youth Services Scheduled Medication Dispensing/Treatment Record form must be completed by the Parent/Guardian.

If your child has an allergy, a Jericho Youth Services Anaphylaxis Action Plan must be completed by the Parent/Guardian.

We strongly recommend every effort be made to discuss medical info with the child's Camp Supervisor!

Signature of Parent/Guardian

Date

Cc: Camp Supervisor
Program Manager

**Jericho Youth Services
2010 Summer Camp – *The Ultimate Experience***

Child Release Waiver Form
(Who can pick up your child from camp)

FORM REQUIRED FOR EVERY CAMP PARTICIPANT!

In order to ensure that your child is safe while at Jericho Youth Services Summer Camp, we require that Parents/Guardians complete this form. Please note that campers are not to be released into the care of any individual other than a parent or authorized caregiver without written consent.

Child's Name: _____

Name of Authorized Individual(s): _____

For the day(s)/week(s) of: _____

Parent/Guardian Name: _____
(Please Print)

Parent/Guardian Signature: _____ **Date:** _____

Talent Release – PLEASE READ & SIGN

I hereby consent that any photograph or any reproduction thereof either whole or in part taken of the stated participant(s) by staff or volunteers of Jericho Youth Services and may be used for any advertising purposes, including non-broadcasting and/or demonstrational use.

Parent/Guardian Signature: _____

TRIP WAIVER

Jericho Youth Services
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2010 ANAPHYLAXIS ACTION PLAN

MY CHILD'S ANAPHYLAXIS TRIGGERS ARE:

peanuts nuts milk all dairy eggs shellfish fish

Food Additives (list):

Insect Stings (list):

Medications (list):

Other (list):

MY CHILD'S ANAPHYLAXIS SYMPTOMS USUALLY ARE:

(Check all that apply)

swelling (eyes, lips, face, tongue)

vomiting

difficulty breathing or swallowing

coughing or choking

cold, clammy, sweaty skin

stomach cramps, diarrhea

flushed face or body

dizziness, confusion

fainting or loss of consciousness

change of voice

others (list):

MY CHILD'S EMERGENCY TREATMENT IS:

anti-histamine+ precise measuring instrument (specify brand and dosage):

Epi-Pen

NOTE: Epi-Pens must be provided.

CALL 911 AND TELL THE DISPATCHER THAT A CHILD IS HAVING A LIFE-THREATENING ANAPHYLACTIC REACTION.

CALL THE PARENT OR GUARDIAN.

Parent / Guardian Signature _____

Date Completed _____

Supervisor Signature _____

Date Completed _____

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Scheduled Medication Dispensing / Treatment Record

To be completed for all scheduled medications and treatments. Parent/Guardian to complete one medication/treatment form, per program. Parent to review at session end. This record to be retained by staff in the program file/binder.

Participant's Name: _____

*must correspond with name on prescription container

Medication/Treatment Information:

Name of Medication: _____ Dosage: _____

Description:

Please check the appropriate box

Tablet

Capsule

Liquid

Spray

Other _____

(Please describe)

Date Prescribed: _____ Start Date: _____ End Date: _____

Storage Instructions: _____

Administration Instructions:

STOP the medication/treatment if:

I release Jericho Youth Services, it's Board of Directors, staff and volunteers from any liability, however caused arising out of the administering, or failure to administer the medication provided herein.

 Parent/Guardian Signature

 Date

Times to Be Administered:

Program Name: _____

Medication Administration Chart

Time	Monday	Tuesday	Wednesday	Thursday	Friday
AM					
PM					

**Checked by staff if child received medication