

Summer Camp

Shepherd's Gate Registration

1725 Brentwood Road, Brentwood, New York 11717

(631) 435-3215

Web site: www.shepherdsgateacademy.com

Today's Date __/__/20

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--|--|
| Parent/Guardian Bill To | Parent/Guardian Phone | | |
| Mother: First Name: _____ Last Name: _____ | Mothers Employer: _____ | | |
| Father First Name: _____ Last Name: _____ | Work Phone: (631) _____ | | |
| Address: _____ | Fathers Employer: _____ | | |
| City: _____ ZIP: _____ | Work Phone: (631) _____ | | |
| Home Phone: (631) _____ | Mom's Cell Phone: _____ | | |
| Home E-Mail: _____ | Dad's Cell Phone: _____ | | |
| Parent: Private <input type="checkbox"/> DSS Approved <input type="checkbox"/> DSS Applying <input type="checkbox"/> Scholarship <input type="checkbox"/> | | | |

If parents are separated or divorced with whom does the child live? _____

Emergency and Alternate Contact Names

| Contact Name | Phone Number | Relationship | Remove from premises Authority? |
|------------------|--------------|--------------|---------------------------------|
| | | | Yes / No |
| | | | Yes / No |
| | | | Yes / No |
| Physician: _____ | Addr: _____ | | |

Enrollment – July +August

| Child's Name | DOB | AGE | Summer Camp Week Desired | | | | | | | |
|--------------|-----|-----|--------------------------|---|---|---|---|---|---|---|
| | | | All 7 weeks | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 1) | | | | | | | | | | |
| 2) | | | | | | | | | | |
| 3) | | | | | | | | | | |

Confirmation of Summer Camp week will be provided only after full payment is received. Guarantee of weeks is assured only on a first-paid first-reserved basis. Every child must pay a non-refundable registration fee of \$150. After a week is paid for, that week belongs to the parent/guardian and the paid tuition thereof is not refundable.

Please Circle One & Initial

Yes No _____ I give permission for pictures to be taken for use by Shepherd's Gate to be displayed in yearbooks, brochures and website purposes, not to be shared with any outside organization.

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| Charges- Internal Use Only | Amount | | Internal use only Weeks reserved |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------|--------------------------------------------------------------------------|
| | Due | Paid | |
| <u>Non-refundable Registration Fee</u> Number of children: _____ x \$150 = | | | Excel ____ Procure ____ File ____ |
| <u>School Age-Full Day</u> 1 st Child: \$250 x weeks ____ = 2 nd Child: \$245 x weeks ____ = | | | |
| <u>School Age- Half day</u> 1 st Child: \$150 x weeks ____ = 2 nd Child: \$150 x weeks ____ = Full Day on trip days 185 x _____ Weeks= | | | (Please Circle Program) AM- 9:00 AM-12 PM PM- 1:00 PM-4:00 PM |
| <u>Pre-K- Full Day</u> 1 st Child: \$250 x weeks ____ = 2 nd Child: \$245 x weeks ____ = | | | |
| <u>Pre-K- Half Day</u> 1 st Child: \$150 x weeks ____ = 2 nd Child: \$150 x weeks ____ = | | | (Please Circle Program) AM- 9:00 AM-12 PM PM- 1:00 PM-4 PM |
| <u>Full Day Daily Rate</u> \$55 X _____ Days X _____ Weeks= \$10 X _____ Trips= | | | M T W Th F |
| <u>Half Day Daily Rate</u> \$35 X _____ Days X _____ Weeks = | | | M T W Th F |
| <u>Extended hrs:</u> before 9:00 AM or after 4:00 PM One Session (AM or PM)\$30 x wks__ (per family) Both AM and PM: \$50 x wks __ (per family) = | | | AM Hours PM Hours (Please Circle) Both |
| Total | | | Balance- |

****Pre-K children do not go on trips unless accompanied by a parent****

NOTE: Drop-off (with early drop-off) at St. Joseph's Academy cannot be earlier than 7:30 AM. Pickup (with late pickup) cannot be later than 5:30 PM. Late pickups after 5:30 PM will incur a late fee of \$1 per minute to pay for required personnel overtime.

Payment Arrangement: A Copy must be given to the client & Accounting Department

Layaway Plan ☐

Payment Plan ☐

Shepherd's Gate Personnel: _____

Date: __/__/20

Parent/Guardian Signature: _____

Date: __/__/20

OF T-SHIRTS-_____ CXS _____ CS _____ CM _____ CL _____ CXL _____ AS _____ AM _____ AL _____ AXL _____

****TSHIRTS MUST BE PAID BY CASH ONLY****

TOTAL \$ _____ PAID ON _____ STAFF INITIALS _____

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Medical Alert:

Does your child have allergies? If yes, to what? Milk, eggs, bee sting, peanuts, etc. What precautions should be observed? Please clearly state any dietary restrictions.

Is your child on daily medication? If yes, describe medication and regimen (Ritalin, insulin, etc.)

Fully describe in writing any physical or emotional limitations.

Medical Emergency: In case of injury or illness to my child, if I cannot be contacted, I hereby grant Shepherd's Gate permission to seek and apply medical aid appropriate to prudent care, this includes calling 911 for proper care if required. _____

Statement of Cooperation

It is my understanding that the policy for Shepherd's Gate is to make no refunds on registration fees. I give Shepherd's Gate permission for my child to take part in all school activities, including bus trips, sports activities and school-sponsored trips away from the school premises. I further agree to hold the school and its agents harmless for any liability to my child or any guardian or parent thereof because of any claims on behalf of my child be taken against Shepherd's Gate or any employee or agent thereof, on my child's behalf and the school or its agent not be found at fault, I agree to pay any attorney fees, court fees, damages or other costs that Shepherd's Gate or its agent should incur to defend itself against such action.

This Statement of Cooperation will be in effect for as long as my children listed (or others to be enrolled) attend Shepherd's Gate whether it be Summer Camp or after school care.

I understand that should my marital status change that it is my responsibility to have a corrected Statement of Cooperation signed and updated and delivered to Shepherd's Gate. Shepherd's Gate admits children of any race, color, religion, and national or ethnic origin.

Mother _____ Father _____

Guardian _____ Date: ____/____/20

Signature for Statement of Cooperation Required

I understand that there is a \$1 per minute fee for lateness after 4 pm or 6 pm if late pick up has been prearranged _____

Additional Information:

Registration Orientation Checklist: For Office Use Only

S.G News Subscription _____ Website Membership _____ Camp Info Packet & Calendar _____

Payment Information _____ Camp Policies _____ Staff Initials _____

DSS Case Worker: _____ Weekly Parent Fee: \$ _____

Phone Number: (631) _____ Coverage: Start Day ____/____/20 End Day: ____/____/20

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Field Trip Transportation Agreement

I, _____, give permission for my child care provider, or any approved
(Name of parent)

employee of the above program, to transport my child(ren) _____
(Name(s) of child(ren))

for the following field trips (Please Initial Below):

_____ July 11th, 2018- Bowling @ Islip Lanes 10 a.m-2 p.m
_____ July 18th, 2018- Belmont Lake, Babylon 10 a.m-3 pm
_____ July 25th, 2018- Long Island Ducks Stadium, Central Islip 10 a.m-4 p.m
_____ August 1st, 2018- Movies, Deer Park 10 a.m-1 p.m
_____ August 8th, 2018- NY Hall of Science Museum 10 a.m-2 p.m
_____ August 15th, 2018- Adventureland, Farmingdale 10 a.m-4 p.m

It is agreed that:

1. The caregiver will never leave my child(ren) unattended in any motor vehicle or other form of transportation.
2. Each child will board or leave a vehicle from the curb side of the street.
3. My child(ren) will be secured in safety seats or by safety belts as appropriate for the age of the child(ren) in accordance with the law.
4. Any motor vehicle used to transport my child(ren) will have current registration and inspection stickers, and must be operated by a person who is at least 18 years of age and possesses a valid driver's license.
5. Staff to child ratios will be maintained throughout the course of the trip. The driver of the bus will not be considered as part of the ratios.

(Parent or Guardian)

(Date)

Sunscreen Permission

The child care provider or her substitutes have my permission to apply sunscreen to my child _____, as needed. I understand I am still responsible for sending my child with Sunscreen already applied daily.

My signature below signifies that I am aware of and agree with the provider's policy of applying sunscreen as needed, and that I am still responsible for applying it to my child prior to drop off every day during the months needed.

(Parent or Guardian)

(Date)

(Office Personnel)

(Date)

Shepherd's Gate Academy Before and After school Care

1725 Brentwood Rd

Brentwood NY 11717

(631)-435-3215-Office

(631)-435-0502- Fax

www.sgbac.org

**PRIVATE PHYSICIAN'S REPORT OF
PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

DATE _____ 20 ____

NAME OF SCHOOL Shepherd's Gate Academy GRADE _____ HOMEROOM _____

| | | |
|------------------------------------------------------------------------------------------------------------------------------------------------|---------------|--------------------------------------------------------------|
| NAME OF CHILD | DATE OF BIRTH | SEX <input type="checkbox"/> M <input type="checkbox"/> F |
| <div style="display: flex; justify-content: space-between;"> _____ Last _____ First _____ Middle </div> | | |

ADDRESS _____

| | | | | | |
|----------------|---------------------|---------------------|--------|-------|----------|
| No. and Street | City or Post Office | Borough or Township | County | State | Zip Code |
|----------------|---------------------|---------------------|--------|-------|----------|

**MEDICAL HISTORY
IMMUNIZATIONS AND TESTS**

| VACCINE | Enter Month, Day, And Year Each Immunization Was Given | | | BOOSTERS & DATES | |
|-------------------------------------------------------|--------------------------------------------------------|-------|-------|------------------|--------------------------------------------------|
| | DOSES | | | | |
| Diphtheria and Tetanus (Circle): DTaP, DTP, DT, Td | 1 / / | 2 / / | 3 / / | 4 / / | 5 / / |
| Polio (Circle): OPV, IPV | 1 / / | 2 / / | 3 / / | 4 / / | 5 / |
| Measles, Mumps, Rubella | 1 / / | 2 / / | | | |
| Hepatitis B | 1 / / | | 2 / / | | 3 / / |
| HIB | 1 / / | | 2 / / | | 3 / / |
| Varicella | 1 / / | | 2 / / | | Varicella Disease or Lab Evidence Date: _____ |
| Other _____ | | | | | |

- ☐ **MEDICAL EXEMPTION** The physical condition of the above named child is such that immunization would endanger life or health
- ☐ **RELIGIOUS EXEMPTION** (includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

If Applicable:

| Tuberculin Tests Date Applied | Arm | Device | Antigen | Manufacturer | Signature |
|----------------------------------|--------------|--------|-----------|--------------|-----------|
| | | | | | |
| Date Read | Results (mm) | | Signature | | |
| | | | | | |

Follow-Up of significant tuberculin tests:

Parent/Guardian notified of significant findings on. _____
Date

Result of Diagnostic Studies: _____
Date

Preventive Anti-Tuberculosis - Chemotherapy ordered. ☐ No ☐ Yes _____
Date

(Continued on Back)

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Significant Medical Conditions (✓)

| | Yes | No | If Yes, Explain |
|---------------------------------|--------------------------|--------------------------|-----------------|
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | |
| Cardiac | <input type="checkbox"/> | <input type="checkbox"/> | |
| Chemical Dependency | <input type="checkbox"/> | <input type="checkbox"/> | |
| Drugs | <input type="checkbox"/> | <input type="checkbox"/> | |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | |
| Diabetes Mellitus | <input type="checkbox"/> | <input type="checkbox"/> | |
| Gastrointestinal Disorder | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hearing Disorder | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | |
| Neuromuscular Disorder | <input type="checkbox"/> | <input type="checkbox"/> | |
| Orthopedic Condition | <input type="checkbox"/> | <input type="checkbox"/> | |
| Respiratory Illness | <input type="checkbox"/> | <input type="checkbox"/> | |
| Seizure Disorder | <input type="checkbox"/> | <input type="checkbox"/> | |
| Skin Disorder | <input type="checkbox"/> | <input type="checkbox"/> | |
| Vision Disorder | <input type="checkbox"/> | <input type="checkbox"/> | |
| Other (Specify) | <input type="checkbox"/> | <input type="checkbox"/> | |

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

Report of Physical Examination (✓)

| | Normal | Abnormal | Not Examined | Comments |
|---------------------------------|--------|----------|--------------|----------|
| • Height (inches) | | | | |
| • Weight (pounds) BMI | | | | |
| • Pulse () | | | | |
| • Blood Pressure / | | | | |
| • Hair/Scalp | | | | |
| • Skin | | | | |
| • Eyes/Vision | | | | |
| • Ears/Hearing | | | | |
| • Nose and Throat | | | | |
| • Teeth and Gingiva | | | | |
| • Lymph Glands | | | | |
| • Heart — Murmur, etc. | | | | |
| • Lung — Adventitious Findings | | | | |
| • Abdomen | | | | |
| • Genitourinary | | | | |
| • Neuromuscular System | | | | |
| • Extremities | | | | |
| • Spine (Presence of Scoliosis) | | | | |

Date of Examination _____

Signature of Examiner _____

Print Name of Examiner _____

Address _____

Telephone Number _____