Summer Camp Shepherd's Gate Registration

25 Church St, Ronkonkoma NY 11779

(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 ☐ DSS Approved ☐ DSS Applying ☐ Scholarship ☐			

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

Emergency and Alternate Contact Names

Contact Name	**Phone Number**	**Relationship**	[1]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.

[1]

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Charges- Internal Use Only	Amount Due	Amount Paid	Internal use only Weeks reserved
Non-refundable Registration Fee Number of children: _____ x $150 =			Excel ___ Procare ____ File ____
School Age-Full Day 1st Child: $200 x weeks ___ = 2nd Child: $195 x weeks___ =			
School Age- Half day 1st Child: $125x weeks ___ = 2nd Child: $120x weeks___ = Full Day on trip days ____x _____ Weeks=			**(Please Circle Program)** **AM- 9:00 AM-12 PM** **PM- 1:00 PM-4:00 PM**
Pre-K- Full Day 1st Child: $200 x weeks ___ = 2nd Child: $195x weeks___ =			
Pre-K- Half Day 1st Child: $125x weeks ___ = 2nd Child: $120 x weeks___ =			**(Please Circle Program)** **AM- 9:00 AM-12 PM** **PM- 1:00 PM-4 PM**
Full Day Daily Rate $50 X _____ Days X _____Weeks= $10 X _____ Trips=			**M T W Th F**
Half Day Daily Rate $35 X ____ Days X _____ Weeks =			**M T W Th F**
Extended hrs: before 9:00 AM **or** after 4:00 PM One Session (AM or PM)$30x 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____

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****TSHIRTS MUST BE PAID BY CASH ONLY**** **TOTAL $_____ PAID ON _____ STAFF INITIALS_____**

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 _____

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DSS Case Worker: _____ Weekly Parent Fee: $_____
Phone Number: (631) _____ Coverage: Start Day ___/___/20 End Day: __/___/20

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 10th, 2019- Bowling @ Islip Lanes 10 a.m-2 p.m

_____ July 18th ,2019- TBA

_____ July 31st, 2019- Movies, Deer Park 10 a.m-1 p.m

_____ August 7th,2019- Long Island Museum10 a.m-2 p.m

_____ August 14th,2019- 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.

_____ _____

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(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
Last First Middle		☐ M ☐ F

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 DOSES			BOOSTERS & DATES	
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	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

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