REGISTRATION
FUN CLUB 2017-2018
ADVENTURE CLUB SUMMER CAMP 2017

THIS DAY CARE FACILITY PARTICIPATES IN THE CHILD AND ADULT CARE FOOD PROGRAM (CACFP), A FEDERAL PROGRAM THAT PROVIDES HEALTHY MEALS AND SNACKS TO CHILDREN RECEIVING DAY CARE.

TODAYS DATE ____________

SUMMER ADVENTURE June 26th - August 18th 2017 FUN CLUB Sep 5th '17-June 21st 2018

Parent/Legal Guardian ____________ Home ____________

Address ____________ Cell ____________

____________ Work ____________

Billing Address ____________ E-Mail ____________

ADVENTURE 2017

Childs Full Name ____________ Male ____ Female ____ D/O/B ____

Camp Registration WEEKS 1-8 9AM-4PM ____ 7:30-9AM ____ 8-9AM ____ 4-6PM ____

WEEKS 1-4 9AM-4PM ____ 7:30-9AM ____ 8-9AM ____ 4-6PM ____

WEEKS 5-8 9AM-4PM ____ 7:30-9AM ____ 8-9AM ____ 4-6PM ____

Camp Friend Request ____________

Camp Shirt Size: **Youth Size** Small ( ) Medium ( ) Large ( ) **Adult Size** Small ( ) Medium ( ) Large ( ) XLarge ( )

FUN CLUB 2017

School Attending 2017 ____________

Fun Club Registration 5 DAYS ____ 4 DAYS ____ 3 DAYS ____ 2 DAYS ____ 7AM ____ 8AM ____

ADVENTURE 2017

Childs Full Name ____________ Male ____ Female ____ D/O/B ____

Camp Registration WEEKS 1-8 9AM-4PM ____ 7:30-9AM ____ 8-9AM ____ 4-6PM ____

WEEKS 1-4 9AM-4PM ____ 7:30-9AM ____ 8-9AM ____ 4-6PM ____

WEEKS 5-8 9AM-4PM ____ 7:30-9AM ____ 8-9AM ____ 4-6PM ____

Camp Friend Request ____________

Camp Shirt Size: **Youth Size** Small ( ) Medium ( ) Large ( ) **Adult Size** Small ( ) Medium ( ) Large ( ) XLarge ( )

FUN CLUB 2017

School Attending 2017 ____________

Fun Club Registration 5 DAYS ____ 4 DAYS ____ 3 DAYS ____ 2 DAYS ____ 7AM ____ 8AM ____

ADVENTURE 2017

Childs Full Name ____________ Male ____ Female ____ D/O/B ____

Camp Registration WEEKS 1-8 9AM-4PM ____ 7:30-9AM ____ 8-9AM ____ 4-6PM ____

WEEKS 1-4 9AM-4PM ____ 7:30-9AM ____ 8-9AM ____ 4-6PM ____

WEEKS 5-8 9AM-4PM ____ 7:30-9AM ____ 8-9AM ____ 4-6PM ____

Camp Friend Request ____________

Camp Shirt Size: **Youth Size** Small ( ) Medium ( ) Large ( ) **Adult Size** Small ( ) Medium ( ) Large ( ) XLarge ( )

FUN CLUB 2017

School Attending 2017 ____________

Fun Club Registration 5 DAYS ____ 4 DAYS ____ 3 DAYS ____ 2 DAYS ____ 7AM ____ 8AM ____

INFORMATION STRICTLY CONFIDENTIAL

Number in Houshold ( ) Single Parent Household ( ) Ethnic Background White ( ) Black or African American ( )
Two or more races ( ) Hispanic or Latino ( ) American Indian or Native Asian ( ) Native Hawaiian or Pacific Islander ( )
<$24,000 ( ) $25,000-$50,000 ( ) $50,000-$80,000 ( ) $81,000 and above ( ) Military Active or Inactive ( )

Adventure 2017 ( )
Fun Club 2017-2018 ( )

FEE PAYMENT CONTRACT

Parents Full Name ______________________ Home # ______________________
Address ______________________ Cell # ______________________

This contract is made between the Parent/Guardian and The Boys & Girls Club of Northern Westchester.
The Child/Children will be attending Summer Adventure Club and/or After School Fun Club 2017

DATE ______________ SIGNATURE OF PARENT/GUARDIAN ______________________

Childs Last Name ______________ First Name ______________ Grade in Sep '17 ________
Childs Last Name ______________ First Name ______________ Grade in Sep '17 ________
Childs Last Name ______________ First Name ______________ Grade in Sep '17 ________
Childs Last Name ______________ First Name ______________ Grade in Sep '17 ________

POLICIES

Tuition Payment:

1. Parents/Guardians are Responsible for Monthly Tuition Payments.
2. Late Fee's of $25 will be Charged after the 15th of the Month of which it is Due.
3. The Boys & Girls Club has the Right to Remove your Child from the Program if Parent is Deliquent on Payments.
4. Children May Not Start Camp or Fun Club if there is a Balance from a Previous Program.

	FEE	NOTES
Program Fee Camp		
Program Fee Fun Club		
Registration Fee Paid		
Deposit Paid		
Financial Aid Award Camp		
Financial Aid Award Fun Club		
Total Payable to the BGC		

Dismissal:

1. Children Must be Picked Up on Time:
   - Camp 4:00PM or 6:00PM
   - Fun Club 6:30PM

Date ______________ Signature of Parent/Guardian ______________________

Barbara E Cutri

Barbara E. Cutri (Director of Operations)

Department of Health | Child and Adult Care Food Program

LETTER TO HOUSEHOLDS

Dear Parent, Guardian or CACFP Participant:

This center participates in the Child and Adult Care Food Program (CACFP) and serves nutritious meals each operating day. The information requested on the attached Income Eligibility Form for Child Care or Adult Day Care Centers determines how much reimbursement this center will receive from CACFP for these meals and snacks, based on the United States Department of Agriculture (USDA) family income criteria listed below.

We encourage you to complete the form promptly so your center can maximize its reimbursement for healthy meals and snacks. One form needs to be completed for each household every year except for children enrolled in Head Start or At-Risk Only programs. All information on the form will be confidential and used only for the purpose of determining CACFP reimbursement for meals and snacks served at this center.

Foster children are automatically eligible for the highest rate of reimbursement from CACFP. Households with both foster and non-foster children in day care may complete one form, including the foster child as a household member. Eligibility determination for the non-foster children will be based on the information reported on the form by the household.

INCOME ELIGIBILITY GUIDELINES
(Effective July 1, 2016 until June 30, 2017)

HOUSEHOLD SIZE	REDUCED-PRICE MEALS		
	YEAR	MONTH	WEEK
1	21,978	1,832	423
2	29,637	2,470	570
3	37,296	3,108	718
4	44,955	3,747	865
5	52,614	4,385	1,012
6	60,273	5,023	1,160
7	67,951	5,663	1,307
8	75,647	6,304	1,455
FOR EACH ADDITIONAL FAMILY MEMBER	+7,696	+642	+148

SPONSOR/CENTER OFFICIAL ______________________ SPONSORING ORGANIZATION ______________________ DATE ____________

This institution is an equal opportunity provider.

CACFP
Child and Adult Care Food Program
New York State Department of Health

INCOME ELIGIBILITY FORM
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME: ______________________________

Print the name of the child(ren) enrolled in this child care center:

1. ____________ 2. ____________ 3. ____________

DIRECTIONS:

Complete SECTION A if anyone in your household:

1. Receives Food Stamps
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. If any of the children enrolled in this child care center are foster children

Complete SECTION B if no one in your household receives Food Stamps, TANF, FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION A

Food Stamp Case Number ____________

TANF Number ____________

FDPIR Number ____________

Names of Foster Children ____________

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature: ____________

Date: ____________

FOR SPONSOR USE ONLY

Sponsor Agreement Number ____________

Total Household Members ____________
(including foster children, if applicable)

Total Income $ ____________

Free ______ Reduced ______ Paid ______

Date Determined ____/____/____

Signature of Center Staff ____________

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

Name of Household Members	Monthly Gross Income
1.	$
2.	$
3.	$
4.	$
5.	$
6.	$

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature: ____________

Print Name: ____________

SS# XXX-XX-__ __ __ __ Date: ____________

Adventure 2017 ( )
Fun Club 2017-2018 ( )

EMERGENCY INFORMATION

Child Name ________ M ( ) F ( ) D/O/B ________ Allergies ________
Child Name ________ M ( ) F ( ) D/O/B ________ Allergies ________
Child Name ________ M ( ) F ( ) D/O/B ________ Allergies ________
Child Name ________ M ( ) F ( ) D/O/B ________ Allergies ________
Parents Full Name ________ E-Mail Address ________
Address ________ Home # ________
________ Cell # ________
________ Work # ________
Physicians Name ________ Phone # ________
Dentists Name ________ Phone # ________
Hospital ________ Phone # ________

EMERGENCY CONTACT INFORMATION

Name ________ Relationship ________
Cell # ________ Home # ________ Work # ________
Name ________ Relationship ________
Cell # ________ Home # ________ Work # ________
Name ________ Relationship ________
Cell # ________ Home # ________ Work # ________
Name ________ Relationship ________
Cell # ________ Home # ________ Work # ________

AGREEMENTS

Yes ( ) No ( ) I consent to the enrollment of the child(ren) listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations un which it operates. I give consent of my child(ren) to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper Supervision.

Yes ( ) No ( ) In case of accident or injury, I authorize any and all emergency medical, dental and/or surgical care and hospitalization advised by the physicians surgeon or hospital necessary for the proper health and well-being of my child(ren)

Yes ( ) No ( ) I have provided information on my child(ren) special needs (Allergies, Diet, Disabilities, and/or Medical information) to the provider, as may be necessary to assist the facility in properly caring for my child(ren) in case of emergency.

Yes ( ) No ( ) I agree to review and update this information whenever a change occurs and at least every six months.

Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.

Date ________ Signature of Parent/Guardian ________

Adventure 2017 ( )
Fun Club 2017-2018 ( )

BOYS & GIRLS CLUB
OF NORTHERN WESTCHESTER

PERMISSION TO PICK UP

Childs Last Name ______________ First Name ______________ Grade in Sep '17 ________
Childs Last Name ______________ First Name ______________ Grade in Sep '17 ________
Childs Last Name ______________ First Name ______________ Grade in Sep '17 ________
Childs Last Name ______________ First Name ______________ Grade in Sep '17 ________

Primary Person Picking Up Child/Children ______________________________

Dated ________ Parent/Guardian Signature ______________________________

I Give Permission For The Following People To Pick Up My Child/Children must present valid photo ID

Name ______________________________ Phone ______________
Name ______________________________ Phone ______________
Name ______________________________ Phone ______________
Name ______________________________ Phone ______________

NOTE: INDIVIDUAL HANDWRITTEN PERMISSION SLIPS ARE REQUIRED FOR ANY PERSON NOT ON THIS LIST TO BE ABLE TO PICK UP YOUR CHILD/CHILDREN FOR PLAY DATES ETC.

Date	Signed Out By:	Time	Date	Signed Out By:	Time

Adventure 2017 ( )
Fun Club 2017-2018 ( )

PROGRAM PERMISSIONS

Childs Last Name ____________ First Name ____________ Grade in Sep '17 ______
Childs Last Name ____________ First Name ____________ Grade in Sep '17 ______
Childs Last Name ____________ First Name ____________ Grade in Sep '17 ______
Childs Last Name ____________ First Name ____________ Grade in Sep '17 ______

(CAMP / FUN CLUB) PERMISSION TO SWIM

I give my Child/Children permission to participate in swimming as a group activity at The Boys & Girls Club of Northern Westchester.

Yes ______ No ______ Parent/Guardian Initial ______

(CAMP / FUN CLUB) PHOTO & VIDEO RELEASE FORM

The Boys & Girls Club of Northern Westchester (BGCNW) has my permission to use my child's photograph publically to promote BGCNW. I understand that the images may be used in print publications, online publications, presentations, websites and social media. I also understand that no royalty, fee or other compensation shall be payable to me by reason of such use.

Yes ______ No ______ Parent/Guardian Signature ______________

(CAMP / FUN CLUB) PERMISSION TO WALK/BUS TRIPS

I give my child permission to attend staff supervised, scheduled and unscheduled walking/bus trips with his or her Boys & Girls Club Group. These trips will occur as part of the Adventure Club/Fun Club Schedule.

Yes ______ No ______ Parent/Guardian Initial ______

(CAMP / FUN CLUB) MENTORING PROGRAM

I, the parent or legal guardian give permission for my child to participate in the Mentoring Program at The Boys & Girls Club of Northern Westchester. I fully understand that the program involves fully screened and trained Boys & Girls Club Staff. Mentoring continues throughout the year, in group format. Children will be provided with individual mentoring, if needed, staff will meet with the parent/guardian.

Yes ______ No ______ Parent/Guardian Initial ______

(FUN CLUB ONLY) CONFERENCE PERMISSION

I,the parent or legal guardian give permission for Barbara E. Cutri and/or the Education Director, to confer with my childs teacher Leader concerning homework issues and/or behavior modification plans, or any special need my child/children have.

Yes ______ No ______ Parent/Guardian Initial ______

Date ____________ Signature of Parent/Guardian ______________

OCFS-LDSS-4433 (Rev. 5/2014) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:

Immunizations required for entry into day care ☐ Yes ☐ No

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date	2nd Date	3rd Date	4th Date	5th Date
Polio (IPV or OPV)	1st Date	2nd Date	3rd Date	4th Date	
Haemophilus influenzae type B (Hib)	1st Date	2nd Date	3rd Date	4th Date **OR** 1st Date (if given on or after 15 months of age)	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date	2nd Date	3rd Date	4th Date	
Hepatitis B	1st Date	2nd Date	3rd Date		
Measles, Mumps and Rubella (MMR)	1st Date	2nd Date			
Varicella (also known as Chicken Pox)	1st Date	2nd Date			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Tests

Tuberculin Test Date: __/__/__ Mantoux Results: ☐ Positive ☐ Negative ______ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: __/__/__

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year __/__/__ Result: ______ mcg/dL ☐ Venous ☐ Capillary

2 years __/__/__ Result: ______ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

__/__/__ Result: ______ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

MEDICATION FORM

* ONLY for Children who must have medication during CAMP or FUN CLUB DAY

*MUST be Filled out By PARENT/GUARDIAN and DOCTOR / HEALTHCARE PROVIDER

*Parents MUST Provide Perscripton/Over Counter Medication

*Medications are DUE to The Boys & Girls Club by FRIDAY before Camp or Fun Club programs begin.

*Medication needs to be in an ORIGINAL CONTAINER with a PERSCRIPTION LABEL

COPLETE BOTH SIDES OF THIS FORM ONLY IF MEDICATION NEEDS TO BE ADMINISTRATED DURING PROGRAM HOURS

OCFS-LDSS-7002 (5/2015) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).

1. Child's First and Last Name:	2. Date of Birth:	3. Child's Known Allergies:

4. Name of Medication *(including strength):*	5. Amount/Dosage to be Given:	6. Route of Administration:

7A. Frequency to be administered:

OR

7B. Identify the symptoms that will necessitate administration of medication: *(signs and symptoms must be observable and, when possible, measurable parameters)*:

8A. Possible side effects: See package insert for complete list of possible side effects *(parent must supply)*

AND/OR

8B: Additional side effects:

9. What action should the child care provider take if side effects are noted:

Contact parent Contact health care provider at phone number provided below

Other *(describe):*

10A. Special instructions: See package insert for complete list of special instructions *(parent must supply)*

AND/OR

10B. Additional special instructions: *(Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situation's when medication should not be administered.)*

11. Reason for medication *(unless confidential by law)*:

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

No Yes If you checked yes, complete (#33 and #35) on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

No Yes If you checked yes, complete (#34 -#35) on the back of this form.

14. Date Health Care Provider Authorized:	15. Date to be Discontinued or Length of Time in Days to be Given:

16. Licensed Authorized Prescriber's Name (please print):	17. Licensed Authorized Prescriber's Telephone Number:

18. Licensed Authorized Prescriber's Signature:
X

COMPLETE BOTH SIDES OF THIS FORM

FUN CLUB ONLY

BEDFORD CENTRAL SCHOOL DISTRICT

2017-2018

APPLICATION FOR DAY CARE TRANSPORTATION

PARENTS: PLEASE FILL OUT THE INFORMATION BELOW AND MAIL THIS FORM TO:
BEDFORD CENTRAL SCHOOL DISTRICT , TRANSPORTATION DEPARTMENT,
PO BOX 180, MT. KISCO NY 10549 OR FAX IT TO US AT 914-244-3475
FOR INFORMATION CALL TRANSPORTATION AT 914-241-6001

SCHOOL ATTENDING____________________________________

STUDENT NAME__________________________ GRADE____________

DAY CARE NAME AND ADDRESS ***BOYS & GIRLS CLUB*** **351 MAIN STREET**

TOWN **MOUNT KISCO** PHONE # AT PROGRAM **(914) 666-8069**

CONTACT PERSON AT PROGRAM **BARBARA E. CUTRI**

PLEASE CHECK DAYS YOU NEED:

MON.		TUES.		WED.		THUR.		FRI.	
AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

PARENT / GUARDIAN FULL NAME__________________________

PARENT / GUARDIAN SIGNATURE__________________________

HOME PHONE__________________ WORK PHONE__________________

OTHER NUMBERS WHERE WE MIGHT REACH YOU________________

½ DAYS & SCHEDULED EARLY DISMISSALS
MY CHILD IS TO BE BUSSED:
HOME ( ) BOYS & GIRLS CLUB ( )

EARLY DISMISSALS DUE TO THE SCHOOL CLOSINGS
(EMERGENCY OR WEATHER RELATED CLOSINGS)
MY CHILD IS TO BE BUSSED:
HOME ( ) BOYS & GIRLS CLUB ( )

THIS FORM MUST BE RECEIVED BEFORE JULY 1ST

IF THIS FORM IS NOT RECEIVED BEFORE JULY 1ST YOUR ABILITY TO RECEIVE TRANSPORTATION MAY BE DELAYED UNTIL OCTOBER.