



FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

# Penobscot Bay YMCA 2023 SUMMER CAMP REGISTRATION FORM

What camp is your child attending?

- Discovery Camp (DC): Ages 4-6
- Snow Bowl Camp (SBC): Ages 7-10
- Before Care (BC)
- Camp Wonder (CW): Ages 7-10
- Adventure Camp (ADV): Ages 11-13
- After Care (AC)

Please check and indicate what weeks of camp will your child be attending by using the abbreviations listed above. Please also indicate if your child is in need of Before or After Care for those weeks.

- Week 1 (6/20-23) \_\_\_\_\_
- Week 2 (6/26-30) \_\_\_\_\_
- Week 3 (7/3-7) \_\_\_\_\_
- Week 4 (7/10-14) \_\_\_\_\_
- Week 5 (7/17-21) \_\_\_\_\_
- Week 6 (7/24-28) \_\_\_\_\_
- Week 7 (7/31-8/4) \_\_\_\_\_
- Week 8 (8/7-11) \_\_\_\_\_
- Week 9 (8/14-18) \_\_\_\_\_

**CAMPER'S NAME:** \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street/PO Box: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Town/City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Camper's T-Shirt Size:  Youth Small  Youth Medium  Youth Large  Youth X-Large  
 Adult Small  Adult Medium  Adult Large  Adult X-Large

**PARENT/GUARDIAN #1 NAME:** \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

What is the best way to reach Parent/Guardian #1? \_\_\_\_\_

Send all email communication to Parent/Guardian #1?  Yes  No

**PARENT/GUARDIAN #2 NAME:** \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

What is the best way to reach Parent/Guardian #2? \_\_\_\_\_

Send all email communication to Parent/Guardian #2?  Yes  No

If we should need to call during the time your child is in our care, which parent/guardian should we try to contact first? \_\_\_\_\_

**EMERGENCY CONTACTS** (in case a parent/guardian as listed above cannot be reached):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Names of persons who are permitted to remove the child from the program:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**\*PLEASE NOTE:** We must be able to contact someone on this form at any time your child is in our care. Please inform us in writing if any of your contact information changes or if you wish to add or remove anyone from the pick-up list.

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

I hereby give my consent, in the event of a medical emergency when I cannot be contacted, for Y staff to obtain whatever treatment may be deemed necessary for:

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Your child's name

Date of birth

This authorization includes my consent for the above-named child to receive treatment by a physician in any hospital emergency department. I hereby give my authorization for emergency medical treatment as outlined above.

Date of last tetanus shot: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Does your child self-administer any medications such as an inhaler or epi-pen?** Please list any medication your child will be taking at camp All medication given to camp director and must come in original bottle with the name of child, medication, dosage, and doctor's name.

\_\_\_\_\_  
\_\_\_\_\_

**Please list any medication your child will be taking at camp.** All medication must be given to the Camp Director and come in original bottle with the name of child, medication, dosage, and doctor's name.

\_\_\_\_\_  
\_\_\_\_\_

**CAMPER MEDICAL HISTORY** (Please check all that apply)

- |                                      |                                      |                                     |
|--------------------------------------|--------------------------------------|-------------------------------------|
| <input type="radio"/> Asthma         | <input type="radio"/> Hypertension   | <input type="radio"/> Epilepsy      |
| <input type="radio"/> German measles | <input type="radio"/> Whooping cough | <input type="radio"/> Mononucleosis |
| <input type="radio"/> Measles        | <input type="radio"/> Scarlet fever  | <input type="radio"/> Diabetes      |
| <input type="radio"/> Heart disease  | <input type="radio"/> Convulsions    | <input type="radio"/> Other _____   |

**ALLERGIES** (Please check all that apply)

- |                                   |   |  |
|-----------------------------------|---|--|
| <input type="radio"/> Animals     | <input type="radio"/> Serious ivy, oak, sumac | <input type="radio"/> Insect bites, stings |
| <input type="radio"/> Penicillin  | <input type="radio"/> Foods                   | <input type="radio"/> Medications          |
| <input type="radio"/> Other _____ |   |  |

**Does your child have any medical conditions we should be aware of?** Also include anything about your child's health that will help the YMCA staff to better understand and work with your child, such as hearing/vision problems, physical needs or behavioral issues (Please attach letter if necessary).

\_\_\_\_\_  
\_\_\_\_\_

**Disabilities or Physical Restrictions:** Please describe any disabilities or physical restrictions of which you want us to be aware and any reasonable adaptations or accommodations that are requested:

\_\_\_\_\_  
\_\_\_\_\_

To ensure we can best serve your child, please answer the following questions:

Does your child have an IEP?  No  Yes If yes, please explain:

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Is your child attending therapy?  No  Yes If yes, please explain:

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Is there anything we should know about your child to ensure their success in our program?

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### CONSENT AND AUTHORIZATION

I approve of my child using his/her own:

**Bug Spray**  No  Yes      **Sun Screen**  No  Yes

Parent/Guardian Initials: \_\_\_\_\_

Penobscot Bay YMCA  
PO Box 840  
116 Union Street  
Rockport, Maine 04856  
Benjie Blake, Camp Director  
207.236.3375  
bblake@penbayymca.org  
www.penbayymca.org

