

JCCSF Spring Camp 2009 Registration Form

Kochav, Sports, GADS and Specialty Camps

Please fill out completely and return to camp office. Please complete one form per child.

Camp Office: (415) 292-1250 or (415) 292-1265 Fax: (415) 276-1561

3200 California Street, San Francisco, CA 94118

Camper Information:

Camper's Name: _____ Home Ph: _____

Mailing Address: _____ City: _____ Zip: _____

Date of Birth: _____ Grade: _____ Male Female JCCSF Member?: Yes No

Parent's Name _____ Work Ph.: _____ Cell /Pager: _____

E-mail Address: _____

Parent's Name _____ Work Ph.: _____ Cell /Pager: _____

Email Address: _____

Emergency Contact (other than parent): _____ Relationship: _____

Home Ph: _____ Work Ph: _____ Cell /Pager: _____

The Following People other than the parents listed above, are authorized to pick up my child:

Has your child attended JCCSF Camp programs in the past? Yes No

How did you hear about camp?: Flyer JCCSF Catalog Ad Word of Mouth Other _____

Does your child participate in other JCCSF programs?: HYC ECE Other _____

What school does your child currently attend?: _____

Medical Release

I authorize the JCCSF and its adult staff to consent to any emergency medical treatment and/or hospital care which is rendered to the above named minor, under the supervision of any physician licensed under the California Medical Practices Act. I authorize approved staff members to transport my child in a personal vehicle in case of a medical emergency or if my child must be moved from a field trip and understand that the JCCSF will verify the clean driving record and auto insurance of all drivers. I grant permission for the above named minor to participate in all camp activities, including field trips, and to swim under the supervision of certified lifeguards. I grant permission for photos to include the above named minor to be used for JCCSF marketing purposes unless otherwise indicated in writing.

Signature: _____ Date: _____

Youth Participant Waiver and Release of Liability

In consideration of my child _____, being allowed to participate in aquatics, sports, dance, camps and/or recreational programs at the Jewish Community Center of San Francisco (JCCSF), the undersigned acknowledges and agrees that:

Participation in aquatics, sports, dance, camps and/or recreational activities can result in physical injuries. While particular rules, equipment and personal discipline may reduce such risks, the risk of injury, including serious injury and disability, does exist.

The undersigned knowingly and freely assumes all such risks, both known and unknown, and assumes full responsibility for the participation of the minor child noted above.

The undersigned, on his or her behalf of the child noted above, and behalf of all heirs, assigns, personal representatives, and next of kin, hereby releases and holds harmless, to the extent permitted by law, the JCCSF, its officers, agents and/or employees, its sponsors, and other participants and their families with respect to any and all injury, disability, death, loss or damage to person or property.

I have read this release of liability and assumption of risk agreement, fully understand its terms, and sign it freely and voluntarily without and inducement.

Signature: _____ Date: _____

Registrations will not be processed without a completed health form.

Turn over for program registration form

Program Registration Form

Camp Kochav (Grades K-6):

There will be no Camp April 9 in observance of the Passover Holiday.
Register by the day. Please mark the box for the **days** you are selecting

MON 4/6 TUES 4/7 WED 4/8 FRI 4/10

Whole Week _____ \$265 (members) or \$285 (public)

Of Days _____ x \$70/day (members) or \$80/day (public) = \$ _____ (YKSCAMP)

Sports Camp (Grades 3-6):

There will be no Camp April 9 in observance of the Passover Holiday.
Please mark the box for the **Camp(s)** you are selecting, If you are combining camps to make a full day please selected the combined option.

- Flag Football Clinic:** 4/6 – 4/8, and 4/10 9:00 am – 12:00 pm
Members \$140 or Public \$150 = \$ _____ (RCAMP1)
- Basketball Clinic:** 4/6 – 4/8, and 4/10 1:00 – 4:00 pm
Members \$140 or Public \$150 = \$ _____ (RCAMP2)
- Combined Flag Football and Basketball Camp:**
4/6 – 4/8, and 4/10 9:00 am – 4:00 pm
Members \$265 or Public \$280 = \$ _____ (RCAMP3)

Specialty Camps:

Please mark the box for the **Camp** you are selecting, 4/6 – 4/8, 9:00 am – 4:00 pm.
There will be no Camp April 9 in observance of the Passover Holiday.

- Visual Arts**
(Grades K-2): 4/6 – 4/8, 9:00 am – 4:00 pm
Members \$210 or Public \$230 = \$ _____ (YKSPART)
- Gymnastics, Art, Dance and Swim Camp**
(Grades 1-4): 4/6 – 4/8, and 4/10, 9:00 am – 4:00 pm
Members \$290 or Public \$310 = \$ _____ (RGADS)
- Culinary Kids**
(Grades 3-5): 4/6 – 4/8, 9:00 am – 4:00 pm
Members \$210 or Public \$230 = \$ _____ (YKSPCUL)

Extended Care:

Please mark the box next to the days you will need either AM or PM Care, total and add to camp fee, total again at bottom.

AM: MON 4/6 TUES 4/7 WED 4/8 FRI 4/10

PM: MON 4/6 TUES 4/7 WED 4/8 FRI 4/10

of Days of Extended Care: _____ x \$6/AM (8:00 – 9:00 am) = \$ _____

_____ x \$12/PM (4:00 – 6:00 pm) = \$ _____

Camp Fee = \$ _____

TOTAL AMOUNT DUE = \$ _____

Payment:

All fees are due in full at time of registration. There will be no refunds after March 13, 2009. There will be a \$35.00 transaction fee assessed per transaction for camp transfers and drops. Financial aid is available for qualified applicants. You may pay by check, American Express, Visa or MasterCard. You will receive a confirmation letter and further information about camp once we have processed your registration.

Please charge my credit card

Type of Card: _____ CC# _____

Check enclosed

Expiration Date _____ Signature: _____



Rabin Spring Camp Programs

Health History Form

Please fill this form out completely. We cannot use forms from previous years.
 Children without completed Health History Forms will not be permitted to attend any camp programs.
 Our staff may need this information in the event your child needs medical attention.

Child's Name _____ **Birth date** _____ **Sex** ___ **Age** _____

Parent or guardian 1 _____

Home Address _____

Home Phone (____) ____ - _____ Work Phone: (____) ____ - _____ Cell Phone: (____) ____ - _____

Parent or Guardian 2 _____

Home Address _____

Home Phone (____) ____ - _____ Work Phone: (____) ____ - _____ Cell Phone: (____) ____ - _____

If parent/guardian is not available in an emergency, notify:

Name _____ Relationship: _____

Home Phone (____) ____ - _____ Work Phone: (____) ____ - _____ Cell Phone: (____) ____ - _____

Does your child...

➔Have allergies to foods, medicine or anything else? _____

➔Have a special diet to follow while in our program? (Kosher, vegetarian, etc...) _____

➔Need to take medication while in our program? If so, please list the medications.

At the start of camp, we will request written instructions from you before administering medication to your child.

Does your child have any special needs? Yes No

If yes, what are those needs? Please explain in detail: _____

Please check the appropriate spaces that apply to your child. If you check "yes," please provide a brief explanation.

Special activities restrictions _____

Serious injuries or operations (in the past 3 years) _____

Hospitalized (How many times) _____

Diabetes _____

Jaundice _____

Bleeding/Clotting Disorders _____

Lung Disease _____

Heart Trouble _____

Convulsions _____

Asthma _____

Other medical concerns _____

Must wear glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has fainted recently	<input type="checkbox"/> Yes <input type="checkbox"/> No
Must wear contact lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bed wets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has frequent nose bleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep walks	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has a prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has a hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No

Has your child had any of the following:

Chicken Pox Measles German Measles Mumps Hepatitis A Hepatitis B Hepatitis C

Female only:

Has your daughter menstruated? _____ If not, has she been told about menstruation? _____

Please provide us with specific medical information listed below:

Name of child's physician _____ Phone _____

Address _____ City/Zip _____

Health Insurance Information

Medical Insurance Company _____

Policy Number _____

Group Number: _____

Immunization History

Please record the date (month & year) of basic immunizations and most recent booster doses.

VACCINE	MO/YR	MO/YR	MO/YR	MO/YR	MO/YR	MO/YR
DTP						
TD						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Haemophilus influenza B						
Hepatitis B						
Varicella (chicken pox)						

TB Mantoux Test

Date of last test: _____ Result: Positive Negative

IMPORTANT-THIS BOX MUST BE COMPLETED FOR ATTENDANCE

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. AUTHORIZATION FOR TREATMENT: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. To my knowledge, all allergies for the named participant are listed on the form above. The completed form may be photocopied for trips out of camp.

Signature of parent or guardian _____

*If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver, which must be signed for attendance.