2022 Summer Camp Application

June 27th- September 2nd

* **Full day**- 9:00-4:00
* **Half day**- 9:00-1:00
* Before Care begins 8:00
* After Care until 6:00

MINIMUM AGE FOR CAMP IS 5 YEARS OLD

ACTIVITIES INCLUDE:

*Instructed gymnastics *open play *inflatables *visitors *outside play *games *themed days * crafts

The more days you come the more you save!!

Full Day	Half Day
$75 per day	$55 per day
10-14 days- 10% off= $67.50 per day	10-14 days- 10% off= $49.50 per day
15-24 days- 15% off= $63.75 per day	15-24 days- 15% off= $46.75 per day
25-34 days- 20% off= $60 per day	25-34 days- 20% off= $44 per day
35+ days- 25% off= $56.25 per day	35+ days- 25% off= $41.25 per day

A $100 deposit is requred/child to reserve your spot. The balance is due by your child's first day of camp.

**10% sibling discount offered* **Please see "Additional Fees and Expenses" page for more pricing info*

Please keep in mind there are NO REFUNDS OR MAKE-UPS allowed for camp!

Please circle: Full Half

	M	T	W	TH	F
Week 1	6/27	6/28	6/29	6/30	7/1
Week 2	X	7/5	7/6	7/7	7/8
Week 3	7/11	7/12	7/13	7/14	7/15
Week 4	7/18	7/19	7/20	7/21	7/22
Week 5	7/25	7/26	7/27	7/28	7/29
Week 6	8/1	8/2	8/3	8/4	8/5
Week 7	8/8	8/9	8/10	8/11	8/12
Week 8	8/15	8/16	8/17	8/18	8/19
Week 9	8/22	8/23	8/24	8/25	8/26
Week 10	8/29	8/30	8/31	9/1	9/2

Check if needed: Before care: ☐ After care: ☐

Camper Name:

Camper Name:

Camper Name:

Contact #:

Email:

Current Student ☐ New Student ☐

An online account must be created in order to register for summer camp. Please visit https://app.thestudiodirector.com/twistersnjgymnastics/portal.sd to create your family profile and add your child as a student.

Scan Here:

Office use only: Total Days:

B/A care total: Visitor Total:

Total Due:

A COPY OF YOUR CHILD'S IMMUNIZATION RECORDS WITH THE DOCOTOR'S STAMP CAN BE SUBMITTED *INSTEAD* OF THIS FORM

HEALTH HISTORY/IMMUNIZATION FORM

(completed by Physician)

Child Name ________________________ DOB ____________ Age ______ Sex _____ Grade just completed ________

Parent (s) / Guardian (s) Name ________________________

Address ________________________

PHYSICAL EXAMINATION

Height ________ Weight ________ Heart _______ Lungs ______ ENT ________ Extrem _______

________ child is found to be healthy and normal and may participate in all Camp activities.

________ child has the following areas of concern ________________________

which will / will not affect participation as follows ________________________

Comments ________________________

HEALTH HISTORY

Previous Communicable Diseases and Dates ________________________

Other Ilnesses, Accidents or Operations and Dates ________________________

Existing Allergies or Chronic Conditions ________________________

Medications ________________________

Special Needs, Individual Limitations ________________________

Previous Screenings, Evaluations, Dates and Results ________________________

IMMUNIZATION RECORD (a copy signed by the doctor can be submitted)

VACCINE TYPE	DISEASE DATE MO/DAY/Y	1ST DOSE MO/DAY/YR	2ND DOSE MO/D/YR	3RD DOSE MO/D/YR	4TH DOSE MO/D/YR	5TH DOSE MO/D/YR	
DIPTHERIA, TETANUS, PERTUSSIS (DTaP) If (Td or DT(1) Indicate	xxxxxxxxx						
POLIO-INACTIVATED POLIO VACCIN (IPV) If Oral, Indicate OPV	xxxxxxxx						
MEASLES, MUMPS, RUBELLA (MMR)							Titer / Date (5):
HAEMOPHILUS B (HIB) (2)	xxxxxxxx						
HEPATITIS B (3)							Titer / Date (5):
VARICELLA (4)							Titer / Date (5):
PNEUMOCOCCAL CONJUGATE (not required)							
OTHER SPECIFY:							

LEAD SCREENING (not required) Test Date: ____________ Result: ____________

Provisional Admission Attached ______ Medical Examination Attached _______ Religious Exemption Attached _______

Date Granted: _______________ * Requires Medical Exemption

(1) Requires Medical Exemtion. (2) Required for Day/Child Care Enrollees (2 months - 5th birthday only)

(3) Required for K-grade 1 (whichever is first). Grade 6 beginning 9-1-01, and grades 9-12, effectve 9-1-04.

(4) Required for Day/Child care enrollees (19 months and older) and grade K-grade 1 (whichever is first) effective 9-1-04.

(5) MMR single antigen receipt requires month/day/year, serologies require titer, and varicella disease history requires month/year.

Physician Name ________________________ Phone ________________

Physician Address ________________________

Physician Signature ________________________ Date ________________

TWISTERS GYMNASTICS SUMMER CAMP 2022
385-A Franklin Ave Rockaway NJ 07866
P. (973) 627-3276 F. (973) 627-3255

MEDICAL PERMISSION FORM & INDIVIDUAL MEDICATION RECORD

If not applicable, please write your child's name, write N/A under all other fields, and sign below.

Child Name ______________________________

Medication ______________________________

Prescription __________ Non Prescription __________ Dr's Approval ________

Condition ______________________________

Amount to be Administered ______________________________

Frequency of Medication ______________________________

Refrigeration Required ________ Yes ________ No

Possible Adverse Reaction (s) ______________________________

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SIGNATURE OF PARENT / GUARDIAN

______________________________ Date ______________

Staff Member(s) authorized to administer medication:

Name ____________________ Signature ____________________

Name ____________________ Signature ____________________