

Xtreme *Camp*



S.T.E.A.M Learning Introducing: The Arts

Child Application

MONTGOMERY COUNTY OIC
CAMP XTREME SUMMER ENRICHMENT PROGRAM REGISTRATION FORM 2025
Montgomery County OIC - Camp Xtreme S.T.E.A.M

Contract Year: 2025

Program Hours:

Montgomery County Opportunities Industrialization Center and Camp Xtreme operate Monday through Friday, 8 am until 5 pm, 10 hours max of care per day. Camp will run from Monday, June 16th through Friday, August 9th (9 weeks).

Health Records:

We must have your children's Health Assessment Record on file before your child/ren can start the program. The state and insurance regulations require that OIC has a current health assessment with the emergency and medical forms properly completed and signed by a physician.

Meals:

Xtreme Summer Camp will provide space for your child to eat their food. Campers are advised to bring lunch as they will not be allowed to have food delivered to them via delivery services.

Payments:

A non-refundable deposit of \$50 is due upon submission of your child's application. Your child may not start without this deposit. Payments are due and accepted weekly on each Friday before the incoming week. Trips are included in the \$300 weekly fee. If you have a trip planned during the camp operating dates, you must provide verbal AND written notices of your child(ren)'s absence so that we have as accurate a count as possible. State subsidies are available for those parents who qualify. You may contact Child Care Information Services (CCIS) for more details on qualifications. They are accepting applications daily. Montgomery County OIC and Camp Xtreme accept money orders, certified checks, cash, Zelle, and automatic electronic billing.

Attendance:

Parents are responsible for notifying the camp when their child will be picked up early or if their child(ren) will be absent or late for any reason. This policy protects the child's safety. Absences of two days or more without prior notice may result in your child being dropped from camp. Additionally, there is a 'waiting list' for Camp Xtreme for those families only looking to participate in specific weeks of camp OR were found out of compliance with Camp Xtreme policy. Attendance is important to the continuity of the program. If all paperwork (i.e., Food Program, Health Assessment, Emergency Contact, and Authorization) is NOT currently up-to-date or wholly filled out correctly, Montgomery County OIC

and Camp Xtreme reserve and will exercise the right to excuse your child(ren) from camp until the paperwork is completed. This is a state regulation.

Liability:

Montgomery County OIC (or any subsidiary/affiliate of the organization) is not responsible for any lost, damaged, or stolen property of your child(ren). All clothing and personal items should be appropriately labeled with your child's name.

I, _____, state that my child(ren) shall participate in all of the activities scheduled during the Camp Xtreme Summer Camp and is medically able and fit to do so. I, _____, will NOT hold any person or representatives of the organization named Montgomery County OIC or its board of directors liable for any claims due to my child(ren) own negligence. I, _____, permit my child(ren) to attend all trips with Camp Xtreme Summer Camp. If I have any questions, I will not hesitate to call 610-279-9700. I HAVE READ THIS CONTRACT, AND I AGREE TO ABIDE BY ITS POLICIES. I ACCEPT THE CONDITIONS LISTED ABOVE.

Parent Signature: _____ Date: _____

Date Application Rec'd: _____ Admission Date: _____ Removal Date: _____

Staff Signature: _____ Date: _____

I have received a Camp Xtreme Handbook (Parent Signature) _____

Weekly Attendance Information – Check all that apply

- ☐ Week 1: June 16 - June 20 ☐ Week 2: June 23 – June 27 ☐ Week 3: June 30 – July 3
☐ Week 4: July 7 – July 11 ☐ Week 5: July 14 – July 18 ☐ Week 6: July 21– July 25 ☐
Week 7: July 28– August 1 ☐ Week 8: August 4 – August 8 ☐ Week 9: August 11 – August 15

Payments must be made every Friday via Procure and/or the Website. Along with the application, two weeks of payment is required. No checks accepted. Cash and/or money orders will also be accepted

MONTGOMERY COUNTY OIC
CAMP XTREME SUMMER ENRICHMENT PROGRAM REGISTRATION FORM 2025
Camp Xtreme Swimming Permission Slip



Arrangements will be made to swim at a locally approved aquatics facility in the Greater Norristown area. Please make sure your child has the necessary water equipment on designated days. This includes but is not limited to a swimsuit, towel, water shoes, and change of clothes. I give _____ permission to go swimming on the scheduled days at the predetermined location. Below, I have listed any concerns or instructions for my child on days at the pool. Special Note: Please pack swimming articles daily since campers may take a trip to the pool on hot days other than predetermined days.

Parent's Signature: _____ Date: _____

Concerns:

MONTGOMERY COUNTY OIC
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CAMP ACTIVITIES AND FIELD TRIPS

All campers must have the approval form signed and on file to participate in the camp trips and related activities. Please sign and return your registration package to Montgomery County OIC.

Participant Name: _____

I AM THE PARENT/LEGAL GUARDIAN OF THE PARTICIPANT MENTIONED ABOVE, AND I REQUEST SUCH PARTICIPANT BE ALLOWED TO PARTICIPATE IN ALL ACTIVITIES AND TRIPS AS PLANNED. I SPECIFICALLY CONSENT TO SUCH PARTICIPANT'S PARTICIPATION, AND I AGREE TO RELEASE AND HOLD HARMLESS MONTGOMERY COUNTY OIC (MONTCO OIC) AND EACH OF ITS OFFICERS, MEMBERS, CHAPERONES, AND AGENTS FROM ANY LIABILITY, INCLUDING INJURY, SICKNESS OR DEATH THAT MAY OCCUR DURING THE TRIP AND RELATED ACTIVITIES.

Parent/Legal Guardian Signature: _____ Date: _____

Please note that some trips may require additional documentation or waivers for the children to participate. If you don't want your child to attend these activities, they may have to remain home if it is a full-day or out-of-town activity.

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:
<input type="checkbox"/> I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.		
PARENT'S SIGNATURE:		

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY): <input type="checkbox"/> NONE
DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY. <input type="checkbox"/> NONE
CHILD'S ALLERGIES (DESCRIBE, IF ANY): <input type="checkbox"/> NONE
LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES. <input type="checkbox"/> NONE
IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)
☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/ID						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

CD 51 09/08

AGREEMENT

55 PA CODE CHAPTERS 3270.123 & 181(C); 3280.123 & 181(a); 3290.123 & 181(a)

NAME OF CHILD		
FEE AMOUNT \$	PER-DAY-WEEK	DAY PAYMENT TO BE MADE
Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)		
CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE \$ 1.00	PER MIN-HR minute	
Extra services to be provided at an additional fee if applicable		

I, the parent/guardian;

☐ received complete written program information at the time of enrollment (§ 3270.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR

DATE

SIGNATURE-PARENT OR GUARDIAN

DATE

DATE OF CHILD'S ADMISSION

DATE OF WITHDRAWAL

PERIODIC REVIEW

SIGNATURE-PARENT OR GUARDIAN

DATE

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EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182; 3280.124 (a)(b), 3280.181 & 182; 3290.124 (a)(b), 3290.181 & 182

CHILD'S NAME			BIRTHDATE
ADDRESS			
MOTHER'S NAME/LEGAL GUARDIAN			HOME TELEPHONE NUMBER
ADDRESS			
BUSINESS NAME			BUSINESS TELEPHONE NUMBER
ADDRESS			
FATHER'S NAME/LEGAL GUARDIAN			HOME TELEPHONE NUMBER
ADDRESS			
BUSINESS NAME			BUSINESS TELEPHONE NUMBER
ADDRESS			
EMERGENCY CONTACT PERSON(S)		NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE
PERSON(S) TO WHOM CHILD MAY BE RELEASED		NAME	ADDRESS
			TELEPHONE NUMBER WHEN CHILD IS IN CARE
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER			TELEPHONE NUMBER
ADDRESS			
SPECIAL DISABILITIES (IF ANY)			ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION			MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD			
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS			POLICY NUMBER (REQUIRED)
PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT			
OBTAINING EMERGENCY MEDICAL CARE		ADMIN. OF MINOR FIRST - AID PROCEDURES	
WALKS AND TRIPS		SWIMMING	
TRANSPORTATION BY THE FACILITY		WADING	

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN

DATE

SIGNATURE OF PARENT or GUARDIAN

DATE

Xtreme
Learning Center

Start Date: _____ **Approved by:** _____ **(Staff Initials)**

Xtreme Child Care Center
A Division of Montgomery County OIC
1101 Arch Street
Norristown, PA 19401
Telephone: 610-279-9700 Fax: 610-279-9705

Child Name: _____
Address: _____
City/Zip Code: _____
Parent's name: _____
Parent's Name: _____

Birthdate: _____
Gender: _____
Home Phone: _____
Cell Phone: _____

Email Address: _____

Does/will child have any siblings enrolled in one of our other programs? Yes__ No__

If Yes, please list them by name: _____

I (parent/guardian) have read and understand the payment procedures and policies. I understand that my child will not be allowed to attend the program if payment has not been received by the OIC prior to my child attending care. I agree to update the emergency contact/parent consent form and agreement form whenever changes occur or every six months at minimum.

I give my permission for OIC to use pictures of my child for advertising and PR.

Parent/Guardian Signature: _____ **Date:** _____

For Office Use Only:

Staff Initials: _____

Date of Registration: _____