For office use only | **REFERRAL SOURCE**_______________

Received_______________
Entered into system_______________
Deposit _______________
Tuition Paid_______________

Agency_______________
Contact_______________
Called_______________

Middletown Goshen Convalescent Children's Home
640 East Main Street, Middletown, NY 10940
(845) 343-8985

2024 CAMPER REGISTRATION FORM

THIS FORM MUST BE COMPLETED BY PARENT/GUARDIAN AND SUBMITTED WITH PAYMENT AND OTHER REQUIRED DOCUMENTS BEFORE REGISTRATION WILL BE ACCEPTED. THE PERSON REGISTERING THIS CAMPER IS RESPONSIBLE FOR MAKING ALL PAYMENTS. PLEASE USE ONE FORM PER CHILD.

Camper's Name _______________ Phone_______________

Address _______________ D.O.B.____/____/__________

City _______________ State ____ Zip __________ Age as of 6/25/24 __________

Camper Gender __________ Biological Sex __________

Custodial Parent / Guardian Name (First & Last Name)

____

Home Phone _______________ Cell _______________Work_______________
Email_______________

Custodial Parent / Guardian Name (First & Last Name)

____

Home Phone: _______________ Cell _______________Work_______________
Email_______________

Camper is in the custody of: ___ Mother ___ Father ___ Both ___ Other_______________

**If special custody arrangements exist, please express in writing and provide documentation*

Name of Person Registering This Camper If Other Than Parent/Guardian

____

Relationship to Camper _______________

Registrant's Phone Number _______________

Email_______________

Camper Emergency Contact Information

Name _______________
Relationship to camper _______________
Home Phone _______________

Name _______________
Relationship to camper _______________
Home Phone _______________
Cell Phone _______________

To register please complete and email entire package Braeside.Nicole@gmail.com.
Once received we will contact you to review paperwork, confirm slot, and finalize payment.

Camper Name:______________________________

Enrollment

	DAY COST (9 AM- 5 PM)	BEFORE CARE (8:00 AM – 9 AM)	AFTER CARE (5 PM – 6PM)	BOTH CARE (8 AM- 6 PM)
	$216	$236	$236	$260
SESSION 1: July 8 – July 13, 2024 *Science & Nature*				
SESSION 2: July 15 – July 19, 2024 *Science Tech Engineering Math*				
SESSION 3: July 22 – July 26, 2024 *Performing Arts*				
SESSION 4: July 29 – August 2, 2024 *Team Sports*				
SESSION 5: August 5 – August 9 *Animals*				
SESSION 6: August 12 – August 16 *More Animals*				
SESSION 7: August 19 – August 23 *Athletics*				
SESSION 8: August 26 – August 30 *Science & Nature*				

Your $50 NON-refundable deposit will be applied to the last week when signing up for multiple sessions.

Breakfast, Lunch, and Snacks provided!

Our overnight summer camp experience has returned in 2024 for one week only!
Contact the office for details!

Medical Insurance

Physician Name______________________________ Telephone ____________________

Address: ______________________________City ____________________ State _______

Medical Insurance

Name of Company ______________________________ Policy Number __________________

Policy Holder's Name ______________________________Relationship to Camper ____________________

Please attach a photo copy of the front and back of all insurance cards to this form.

In the Event of an Emergency Authorization

I hereby give permission to the medical personnel selected by Braeside Camp to order x-rays, routine tests and treatment for my child, and in the event I cannot be reached, I hereby give permission to the physician selected by Braeside Camp to hospitalize, secure proper treatment for and to order injection and /or anesthesia and/or surgery for my child as named above. This form may be photocopied for use off of property. I also give permission for routine medical care for my child by Braeside Camp.

____

Parent/Guardian signature **Date**

Medications

NAME OF CHILD: ____

If your child should become ill or injured at camp, the medical director has the following:

Tylenol	**Ibuprofen**	**Benadryl**
Aspirin	**Ivy rest (for poison ivy)**	**Robitussin**
Eye drops	**Neosporin (antibiotic cream)**	**Throat spray/Cough drops**
Vaseline/Dry skin cream	**Hydrogen peroxide**	**Hydrocortisone cream**
Ear-Dry	**Bacitracin ointment**	**Bactine**
Isopropyl alcohol	**Antiseptic wipes**	**Calagel/Calamine lotion**

This form serves as your consent for the child to self-administer the above medications if needed during camp.

If you do not want your child to have any of the above, please draw a line through it and initial.

If your child has been prescribed medications, please list them below.

It is the responsibility of the parent/guardian to refill prescriptions.

All prescribed medications must meet the following criteria:
- **Medications must be in their original containers.**
- **All medications must be labeled correctly (no damaged labels):**
- **Complete name of patient.**
- **Date prescription filled.**
- **Expiration date.**
- **Directions for use/precautions (if any)/storage (if any).**
- **Name and address of dispensing pharmacy.**
- **Name of physician prescribing medication.**

Prescribed medications not following the above criteria will not be accepted by the medical director. If you have over-the-counter medications that your child takes on a regular basis, please include written authorization for the child to take such medication below or on the back of this page and ensure that the medication is in its original container and is correctly labeled.

Please note that all medications must be checked in and locked away inside the Infirmary.

PRESCRIPTIONS/OTHER MEDICATIONS: ________________________________

____

____

____

____

SIGNATURE OF PARENT/GUARDIAN **DATE**

Authorizations

CONSENT TO TREAT A MINOR TEMPORARILY SEPARATED FROM PARENTS/GUARDIANS

I/We, the undersigned, parent(s)/guardian(s) of ______________________________, a minor, do hereby authorize Braeside Camp as our agent to consent to any diagnostic procedure or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician and surgeon on the staff of, or engaged by, Hospital selected by Braeside Camp, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of our aforesaid agent to give specific consent to any and all such diagnosis, treatment, or hospital care which the physician in the exercise of his best judgment may deem advisable.

In consideration of the treatment to be rendered to the aforementioned minor, we do hereby release the Hospital and any physicians acting in connection or in conjunction therewith from any and all liability for failure of the parent to be specifically present and specifically consent to the treatment rendered to the aforementioned minor, so long as treatment is rendered in good faith and in the considered judgment of the physician and/or hospital as necessary and indicated under the circumstances.

This authorization shall remain effective until September 5, 2024.

____
Camper Name

____
Parent/Guardian signature **Date**

____
Parent/Guardian signature **Date**

REALEASE FROM LIABILITY

I give permission for my child to participate in any activities, and I recognize that there are inherent risks in most camp activities.

In the case this application should be granted and said child be admitted to Braeside Camp, I do hereby individually, and on behalf of said child, agree to save the committee conducting Braeside Camp and each and every Official connected therewith, harmless as against any and all claims which either I or the said child might have because of injuries, accidents or sickness which said child might suffer while at Braeside Camp.

____
Parent/Guardian signature **Date**

PHOTO RELEASE

Braeside Camp may take pictures and/or videos for use as camp promotional material for the camp and/or programs and I realize that my child's likeness and/or mine may appear in this material.

____
Parent/Guardian signature **Date**