Bexley Recreation & Parks

Jeffrey Summer Camp Program
Registration Form

Jeffrey Summer Camp Program — CJW, CJP, PC, CA — "Building Lifelong Relationships"

Please register for one of the following camps by checking the appropriate box:

Playcamp (4 & 5 Year Old)	**Camp Jeffrey Woods**	**Camp Jeffrey Park**	**Camp Adventure**
☐ 3-Day Half ☐ 3-Day Full (M-W-F) ☐ 5-Day Half ☐ 5-Day Full (M-F)	(Entering 1st – Entering 3rd Grade)	(Entering 4th – Entering 7th Grade)	(Entering 7th – Entering 9th Grade)

Please print clearly in all sections.

Child's Name _____ DOB____/____/____ Age____ Sex____ Grade (2016-17) _____

Parent(s) Name _____ Address _____

Email _____ Phone: Home _____ Work _____

Please check ☐ if you do not wish to receive camp related text messages. Cell _____ Provider _____
(At&t, Verizon, Sprint, etc.)

Other parent (if different than above)

Parent(s) Name _____ Address _____

Email _____ Phone: Home _____ Work _____

Please check ☐ if you do not wish to receive camp related text messages. Cell _____ Provider_____
(At&t, Verizon, Sprint, etc.)

T-Shirt Size: ***(Youth)*** Small ☐ Medium ☐ Large ☐ ***(Adult)*** Small ☐ Medium ☐ Large ☐ XLarge ☐

1. Due to new licensing regulations, Camp Woods and Camp Park will have two separate camp options within the individual camp. (AM Woods and PM Woods / AM Park and PM Park). AM camps will run from 7a - 1230p and PM camps will run from 1230 - 6p. Playcamp and Camp Adventure will continue being the same with no changes. With the time changes this will not change the structure of how camp runs day to day, but now we have the flexibility for campers to come only for the am hours or pm hours.
2. Charges for these camps will be $104 AM or PM Camps (Residents), $120 AM or PM Camps (Non- Residents). If you say yes to **Both AM and PM Camps**, then you will still be charged $165 (Residents) / $190 (Non-Residents) each week.
3. If your child wants to participate in Field Trips, they will need to be registered for **Both AM and PM Camps.**

Please write yes or no in the weeks designed for your child specific to his/her camp.

Week	Date	Playcamp (4 &5 yr.)	CJ Woods (1st - 3rd)		CJ Park (4th - 7th)		Adventure (7th - 9th)	Payment Received By
			AM (7a-1230p)	PM (1230-6p)	AM (7a-1230p)	PM (1230-6p)		
Week 1	May 31 - Jun. 3*							Wed., May 18, 2016
Week 2	Jun. 6 - Jun. 10							Wed., May 25, 2016
Week 3	Jun. 13 - Jun. 17							Wed., Jun. 1, 2016
Week 4	Jun. 20 - Jun. 24							Wed., Jun. 8, 2016
Week 5	Jun. 27 - Jul. 1							Wed., Jun. 15, 2016
Week 6	Jul. 5 - Jul. 8							Wed., Jun. 22, 2016
Week 7	Jul. 11 - Jul. 15							Wed., Jun. 29, 2016
Week 8	Jul. 18 - Jul. 22							Wed., Jul. 6, 2016
Week 9	Jul. 25 - Jul. 29**							Wed., Jul. 13, 2016
Week 10	Aug. 1 - Aug. 5							Wed., Jul. 20, 2016
Week 11	Aug. 8 - Aug. 12							Wed., Jul. 27, 2016
Week 11½	Aug. 15 - Aug. 16 ($70)							Wed., Aug. 3, 2016

**Prorated*
***Last week of Adventure Camp, Over-Night White Water Rafting, $200.*

RELEASE / PERMISSION

I, as parent or legal guardian representing this minor, agree to release the City of Bexley, its officers, employees and volunteers from any and all liability for accidents, injuries, loss of and / or damage to my / our person or property that may arise out of my child's participation in or at the listed activity / activities. I / we are aware that participating in activities or use of facilities involves certain risk of injury despite safety precautions. I give permission for my child to take part in all camp activities, including trips away from camp. In the event of an accident or emergency, if my child's physician is not available, I grant permission to call another licensed physician. I authorize the camp staff to act for me according to their best judgment. I have read the Summer Camp policies and payment terms and accept full responsibility for 100% payment of all camp fees.

_____ _____
Signature of Parent, Custodian, or Guardian **Date**

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE CENTERS AND TYPE A HOMES

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth	First Day at Center
Home Address			City
State	Zip Code	Home Telephone Number	

Parent/Guardian Name	Relationship to Child
Home Address	Home Telephone Number
City	State / Zip
Email Address *(if applicable)*	Cell Phone
Parent's Work/School Telephone Number	Parent's Work/School Name
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program?

Parent/Guardian Name	Relationship to Child
Home Address	Home Telephone Number
City	State / Zip
Email Address (if applicable)	Cell Phone
Parent's Work/School Telephone Number	Parent's Work/School Name
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)		Other numbers where emergency contact can be reached (if applicable)	

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or type A home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - check all that apply ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ No (If no, fill out the following)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the center/type A home's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			**OR**	***Do Not Give Permission* to Transport**	
Center or Type A Home Name				Center or Type A Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			**Do not sign both**	**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date			Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the center's or type A home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care. After the child is attending the program the administrator shall have the parent/guardian review and initial the form when any changes/updates are made and at least annually. The parent/guardian and the administrator or designee shall initial and date the form in the section below to indicate when the form was last reviewed.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by centers and type A homes to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37. This form must be on file at the center or type A home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth
☐ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.	
Signature of Examining Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Date of Examination
Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Telephone Number
Street Address	
City, State and Zip Code	

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

	PHYSICIAN /PHYSICIAN'S ASSISTANT/ADVANCED PRACTICE NURSE/CERTIFIED NURSE PRACTITIONER COMPLETES *check all that apply for each disease*		
Diseases for Immunization	**Immunized**	**In Process of Immunization**	**Medically Contraindicated/ Not Age Appropriate**
Chicken pox	☐	☐	☐
Diphtheria	☐	☐	☐
Haemophilus influenzae type b	☐	☐	☐
Hepatitis A	☐	☐	☐
Hepatitis B	☐	☐	☐
Influenza ☐ Seasonal Vaccine Not Available	☐	☐	☐
Measles	☐	☐	☐
Mumps	☐	☐	☐
Pertussis	☐	☐	☐
Pneumococcal disease	☐	☐	☐
Poliomyelitis	☐	☐	☐
Rotavirus	☐	☐	☐
Rubella	☐	☐	☐
Tetanus	☐	☐	☐

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Initial beside the disease(s) being declined above and sign below.

Signature of Parent	Date of Signature

Recommended Assessments/Screenings			
Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other	

Measurements:		**Notes:**
Height	)	)
Weight	)	)
BMI		

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION

Child Care Centers and Type A Homes

This form is valid for no longer than twelve (12) months. One form must be used for each medication.

Box 1 - The following section must **always** be completed by the parent/guardian.

Check all that apply:

- ☐ Prescription medication
- ☐ Nonprescription medication
- ☐ Refrigeration required
- ☒ Topical product or lotion
- ☐ Food supplement
- ☐ Modified diet

Complete all of the following information:

Name of child: _____ Date of birth: _____ Weight _____

Name of medication: Hand Sanitizer Exact dosage: 1 Pump

To be administered at the following times: Before Eating

For the following period of time: While Attending Camp

Parent/Guardian signature: _____ Date: _____

Box 2 -The following section must be completed by a **licensed physician, a licensed dentist or an advance practice nurse** when:

1. A physician's instruction is needed for a nonprescription medication (e.g. child is underage or underweight per the label instructions); or
2. It is a sample medication without a prescription label; or
3. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period or is a topical product or lotion that is being used for a skin ailment and is to be given no longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated); or
5. The medication contains codeine or aspirin.

_____ is under my care and should receive _____
(name of child) (name of medication, vitamin, diet)

as follows: _____
(include dosage and instructions)

Possible side effects to watch for are: _____

Expiration date: _____ (may not exceed 12 months from the date of this request for medications or food supplements)

_____ _____ _____
Signature of physician, dentist or advance practice nurse Date of signature Phone number

This form must be used by child care centers and type A homes to meet the requirement of rules 5101:2-12-31 and 51-1:2-13-31.

Box 3 - The section below must be completed by the **center or type A home staff** and each administration of medication must be documented. **All** dosages must be recorded on the reverse side of this form.

_____ was given _____ in the amount of _____
(Name of Child) (Name of Medication, Vitamin or Diet) (Dosage)

Date and Time of Dosage	Dosage Amount	Signature of Designated Person Administering Medication

This form must be used by child care centers and type A homes to meet the requirement of rules 5101:2-12-31 and 51-1:2-13-31.

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION

Child Care Centers and Type A Homes

This form is valid for no longer than twelve (12) months. One form must be used for each medication.

Box 1 - The following section must **always** be completed by the parent/guardian.

Check all that apply:

- ☐ Prescription medication
- ☐ Nonprescription medication
- ☐ Refrigeration required
- ☒ Topical product or lotion
- ☐ Food supplement
- ☐ Modified diet

Complete all of the following information:

Name of child: _____ Date of birth: _____ Weight _____

Name of medication: Sunscreen Exact dosage: 2 Tablespoons

To be administered at the following times: During Camp Hours

For the following period of time: While Attending Camp

Parent/Guardian signature: _____ Date: _____

Box 2 -The following section must be completed by a **licensed physician, a licensed dentist or an advance practice nurse** when:

1. A physician's instruction is needed for a nonprescription medication (e.g. child is underage or underweight per the label instructions); or
2. It is a sample medication without a prescription label; or
3. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period or is a topical product or lotion that is being used for a skin ailment and is to be given no longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated); or
5. The medication contains codeine or aspirin.

_____ is under my care and should receive _____
(name of child) (name of medication, vitamin, diet)

as follows: _____
(include dosage and instructions)

Possible side effects to watch for are: _____

Expiration date: _____ (may not exceed 12 months from the date of this request for medications or food supplements)

_____ _____ _____
Signature of physician, dentist or advance practice nurse Date of signature Phone number

This form must be used by child care centers and type A homes to meet the requirement of rules 5101:2-12-31 and 51-1:2-13-31.

Box 3 - The section below must be completed by the **center or type A home staff** and each administration of medication must be documented. **All** dosages must be recorded on the reverse side of this form.

_____ was given _____ in the amount of _____
(Name of Child) (Name of Medication, Vitamin or Diet) (Dosage)

Date and Time of Dosage	Dosage Amount	Signature of Designated Person Administering Medication

This form must be used by child care centers and type A homes to meet the requirement of rules 5101:2-12-31 and 51-1:2-13-31.

Bexley Recreation & Parks

Jeffrey Summer Camp Program
Dismissal Form

Jeffrey Summer Camp Program
CJW CJP PC CA
"Building Lifelong Relationships"

*****ONLY ONE FORM NEEDED PER FAMILY*****

Playcamp (4 & 5 Year Old)	Camp Jeffrey Woods	Camp Jeffrey Park	Camp Adventure
3-Day Half 3-Day Full (M-W-F) 5-Day Half 5-Day Full (M-F)	(Entering 1st – Entering 3rd Grade)	(Entering 4th – Entering 7th Grade)	(Entering 7th – Entering 9th Grade)

The following persons have my permission to pick up my child(ren) from Jeffrey Summer Camp.
I understand that my child(ren) will not be released without a picture ID.

Reminder: Campers, at no time, are allowed to sign themselves out of camp.

Child's Name:_____ **Camp:**_____

Child's Name:_____ **Camp:**_____

Child's Name:_____ **Camp:**_____

Child's Name:_____ **Camp:**_____

Name of Authorized Person(s)	**Relationship to Child**
1. _____	_____Parent/Guardian_____
2. _____	_____Parent/Guardian_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____

Parent Name: _____

Parent Signature: _____ **Date:** _____

Comments:

_____

_____

_____

_____

_____

Bexley Recreation & Parks

Jeffrey Sumer Camp Program
Permission/Photo Release Form

Jeffrey Summer Camp Program
"Building Lifelong Relationships"

*****ONLY ONE FORM NEEDED PER FAMILY*****

Playcamp (4 & 5 Year Old)	Camp Jeffrey Woods	Camp Jeffrey Park	Camp Adventure
3-Day Half 3-Day Full (M-W-F) 5-Day Half 5-Day Full (M-F)	(Entering 1st – Entering 3rd Grade)	(Entering 4th– Entering 7th Grade)	(Entering 7th – Entering 9th Grade)

Parent's Name _____**Best Available #**_____ **#**_____

Secondary Contact _____**Best Available #**_____ **#**_____

Liability Release

I hereby grant my child permission to accompany his/her group on the above field trip(s), and do also hereby release the Bexley Recreation Department, drivers, and supervisors (staff or other) of all responsibility for any injuries which might occur traveling to and from their destination, or at their destination. I, as participant or legal guardian representing a minor participant, agree to release the City of Bexley, its officers, employees and volunteers from any and all liability for accidents, injuries, loss of and/or damage to my/our person or property that may arise out of my/our participation in our presence at the listed activity/activities. I/we are aware that there are certain risks of possible dangers in participation in this activity. I have entered into this agreement of my own free will.

Transportation by the Bexley City Schools and/or other Certified Transportation Company

The field trips will be scheduled between camp registration and the parent meeting.
A handout will be passed out at the parent meeting listing the field trips for the current summer.
This permission slip covers all scheduled trips for the Jeffrey Summer Camp Program 2016.

Photographic Release

I, the undersigned participant (age 18 or older) or parent/guardian of a participant (under the age of 18), hereby give permission without restrictions to the Bexley Recreation Department and its designees or licensees to photograph, film, video or take sound recordings of me or my child, as the case may be, in connection with such participation in Bexley Recreation Department programs.

I grant the Bexley Recreation Department permission of use the negatives, prints, motion pictures, videos, digital images, and/or sound recordings, or any reproduction thereof, for promotional, informational and instructional purposes in any manner determined to be appropriate by the Bexley Recreation Department.

I waive any right to compensation or monetary damages with respect to such use by the Bexley Recreation Department of my, or my child's, name, likeness, picture and/or voice, including without limitation any claim for invasion of privacy.

I have read and understand the terms of this Photographic Release, and I am signing this release as my free and voluntary act, irrevocably binding myself, my child (if applicable) and my heirs and personal representatives.

Child's Name:_____ Camp:_____

Child's Name:_____ Camp:_____

Child's Name:_____ Camp:_____

Child's Name:_____ Camp:_____

Parent/Guardian's Name_____

(Please Print)

Parent/Guardian's Signature_____**Date**_____

Revised January 16

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION

Child Care Centers and Type A Homes

This form is valid for no longer than twelve (12) months. One form must be used for each medication.

Box 1 - The following section must **always** be completed by the parent/guardian.

Check all that apply:

- ☐ Prescription medication
- ☐ Nonprescription medication
- ☐ Refrigeration required
- ☐ Topical product or lotion
- ☐ Food supplement
- ☐ Modified diet

Complete all of the following information:

Name of child: _____ Date of birth: _____ Weight _____

Name of medication: _____ Exact dosage: _____

To be administered at the following times: _____

For the following period of time: _____

Parent/Guardian signature: _____ Date: _____

Box 2 -The following section must be completed by a **licensed physician, a licensed dentist or an advance practice nurse** when:

1. A physician's instruction is needed for a nonprescription medication (e.g. child is underage or underweight per the label instructions); or
2. It is a sample medication without a prescription label; or
3. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period or is a topical product or lotion that is being used for a skin ailment and is to be given no longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated); or
5. The medication contains codeine or aspirin.

_____ is under my care and should receive _____
(name of child) (name of medication, vitamin, diet)

as follows: _____
(include dosage and instructions)

Possible side effects to watch for are: _____

Expiration date: _____ (may not exceed 12 months from the date of this request for medications or food supplements)

_____ _____ _____
Signature of physician, dentist or advance practice nurse Date of signature Phone number

This form must be used by child care centers and type A homes to meet the requirement of rules 5101:2-12-31 and 51-1:2-13-31.

Box 3 - The section below must be completed by the **center or type A home staff** and each administration of medication must be documented. **All** dosages must be recorded on the reverse side of this form.

_____ was given _____ in the amount of _____
(Name of Child) (Name of Medication, Vitamin or Diet) (Dosage)

Date and Time of Dosage	Dosage Amount	Signature of Designated Person Administering Medication

This form must be used by child care centers and type A homes to meet the requirement of rules 5101:2-12-31 and 51-1:2-13-31.

Ohio Department of Job and Family Services

CHILD CARE PLAN FOR HEALTH CONDITIONS OR MEDICAL PROCEDURES FOR CHILD CARE CENTERS AND TYPE A HOMES

If care is provided for a child who has an ongoing health condition that requires child specific care or may require a medical procedure, the parent/guardian shall complete this form. The center staff shall implement the plan. This requirement does not include short term illnesses, unless the child care staff member needs to perform a medical procedure for the child. A separate plan must be written for each condition that requires different actions to be taken.

Child's Name	Date of Birth

Describe the health condition.

Describe the medical procedure to be completed and expected benefits of treatment, or ☐ N/A, no medical procedure required.

List activities/foods/environmental conditions to avoid or ☐ N/A, nothing to avoid.

Symptoms to watch for and actions to be taken if the symptoms are observed.

Is any medication required? ☐ Yes ☐ No
(If yes, complete JFS 01217 "Request for Administration of Medication", in addition to this form.)

In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate? ☐ Yes ☐ No If yes, please describe:

In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child? ☐ Yes ☐ No If yes, please describe:

Signature of Trainer (Trainer must be a parent/guardian or certified professional)	Date

Signature of child care staff members who have been informed about the child's condition so they can care for the child according to this care plan or trained to perform the medical procedure.

There must always be a trained staff member present when the child is present.

Signature	Date	I have been ☐ **Informed**	I have been ☐ Trained
Signature	Date	☐	☐
Signature	Date	☐	☐
Signature	Date	☐	☐

I give my permission for the staff listed above to perform the procedures in my child's care plan as described above.

Parent's Signature	Date

Administrator's Signature	Date

This form may be used for children with health conditions as defined in Rules 5101: 2-12-38 and 5101: 2-13-38.

Ohio Department of Job and Family Services

PERMISSION TO PARTICIPATE IN SWIMMING ACTIVITIES
CHILD CARE CENTERS AND TYPE A HOMES

Licensing rules 5101:2-12-17 and 5101:2-13-17 require parental permission for the water activities your child will be engaging in: (check all that apply for this activity)

- ☑ Before the child swims in water two feet or more in depth.
- ☐ Before the child participates in activities *near* water two feet or more in depth - no water activities planned.
- ☐ Before infants and toddlers use wading pools.
- ☐ Before school children participate in swimming activities in lakes, rivers, ponds, creeks, or other similar bodies of water.

(Check one)

- ☑ The center will be providing _____ additional adults above the required staff /child ratios.
- ☐ The center will NOT be providing additional adults above the required staff /child ratios. (Required ratio is: _____)

I give permission for my child to participate in the following swimming/water activities:

Swim site	Bexley Pool
Date(s)	May 31 - August 16 2016
Departure/Arrival Times from Center	On Site
Mode of Transportation (parent's driving, provider vehicle, public transportation, school bus, etc.)	On Site
Child's Name and Date of Birth	

My child is a: ☐ **Swimmer** ☐ **Non swimmer**

Parent Signature **Date**

This is a sample form provided by ODJFS.

JFS 01227 (Rev. 1/2007)

David H. Madison Bexley Pool
Recreation and Parks Department

Office Use Only	*JSCP ONLY*
Amount Pd. To Bexley Rec: $_____	
Check #:_____ Credit: VS MC # _____	
PC _____ Woods/Park _____ Charge CC on File: ____	

Learn To Swim Program Registration Form
For JSCP Participants

Name _____Birth Date _____ Age _____ Gender _____

Address _____

Phone _____ Email _____

Father's Name _____ Mother's Name _____

Emergency Contact (other than parent) _____

Emergency Phone(s) _____

Youth Swim Lesson Program

Times will be assigned based on which camp your child attends. You will receive an email from your camp director confirming your child's time before lessons begin.

Date: June 13 – July 21
Day: Monday – Thursday
Fee: $80

What camp does your child attend? _____ Playcamp (4-5) _____ Woods (1st-3rd) _____ Park (4th-6th)

Charge my JSCP credit card on file? _____ Yes* _____ No, I will make payment with a check or different credit card.
**By checking Yes, you give BRPD permission to charge your JSCP Credit Card on file for 2016 swim lessons.*

Refund Policy
There will be no refunds or prorated rates for any weeks missed throughout the summer. If your child is not registered for a week of camp during swim lessons, then you are welcome to bring your child to swim lessons during his/her normal time.

Weather Cancellation Policy
Lessons may be cancelled due to the weather. Make-ups will be determined by the Swim Lesson Director and will be available at the end of the season if needed.

Liability Release

I, as parent or legal guardian representing a minor participant, agree to release the City of Bexley, it's officers, employees and volunteers from any and all liability for accidents, injuries, loss of and/or damage to my/our person or property that may arise out of my child's participation in or at the Bexley Recreation Department's program by American Red Cross: Learn To Swim Program. I am aware that participating in these activities or use of facilities involves certain risks of accidental injury despite safety precautions. I give my permission for my child to take part in said activity. In the event of an accident or emergency, if my child's physician is not available, I grant permission to call another licensed physician. I authorize staff to act for me according to their best judgment.

Photo Release

I, as parent or legal guardian representing a minor participant, am aware that pictures may be taken by Recreation Staff during programs/activities and may be used on the City of Bexley/Recreation website, program brochure or flyers to better enhance the advertisement of the Recreation Department. I give my permission for the City of Bexley/Recreation Department to take pictures of my child during this recreational activity/program.

_____ _____
Parent/Guardian Signature Date

Bexley Recreation & Parks

Jeffery Summer Camp Program
Deposit & Direct Withdrawal Form

Jeffrey Summer Camp Program — CJW, CJP, PC, CA — "Building Lifelong Relationships"

Name of Child/Children:

1. _____

Playcamp (4 & 5 Year Old)	Camp Jeffrey Woods	Camp Jeffrey Park	Camp Adventure
☐ 3-Day Half ☐ 3-Day Full (M-W-F) ☐ 5-Day Half ☐ 5-Day Full (M-F)	(Entering 1st – Entering 3rd Grade)	(Entering 4th – Entering 7th Grade)	(Entering 7th – Entering 9th Grade)

2. _____

Playcamp (4 & 5 Year Old)	Camp Jeffrey Woods	Camp Jeffrey Park	Camp Adventure
☐ 3-Day Half ☐ 3-Day Full (M-W-F) ☐ 5-Day Half ☐ 5-Day Full (M-F)	(Entering 1st – Entering 3rd Grade)	(Entering 4th – Entering 7th Grade)	(Entering 7th – Entering 9th Grade)

3. _____

Playcamp (4 & 5 Year Old)	Camp Jeffrey Woods	Camp Jeffrey Park	Camp Adventure
☐ 3-Day Half ☐ 3-Day Full (M-W-F) ☐ 5-Day Half ☐ 5-Day Full (M-F)	(Entering 1st – Entering 3rd Grade)	(Entering 4th – Entering 7th Grade)	(Entering 7th – Entering 9th Grade)

4. _____

Playcamp (4 & 5 Year Old)	Camp Jeffrey Woods	Camp Jeffrey Park	Camp Adventure
☐ 3-Day Half ☐ 3-Day Full (M-W-F) ☐ 5-Day Half ☐ 5-Day Full (M-F)	(Entering 1st – Entering 3rd Grade)	(Entering 4th – Entering 7th Grade)	(Entering 7th – Entering 9th Grade)

Name on Card:_____ **Credit Card Type:** ____**VISA** ____**MC**

Account #_____- _____ - _____ - _____ **Exp. Date:**____ / ____ **3-Digit Code:**_____

REGISTRATION / PAYMENT POLICY

All credit cards will be charged for a one week camp tuition fee per child on April 7, 2016. This fee will be applied to the last week your child attends camp. Please check the WEEKLY box to sign up for direct withdrawal, where the above card number will be charged on the Thursday two weeks prior to the week of attendance. Any failure to pay in full by the specified deadline could result in a withdrawal from camp for that week.

CANCELLATION POLICY

There will be **NO** cancellation fee for cancellation of weeks made at or prior to the JSCP Parent Meeting on Sunday, May 1, 2016. Cancellations made after the JSCP Parent meeting will include a $25 cancellation fee. Parents must notify in writing to the Camp Administrator of withdrawal by the Monday at 6pm two weeks prior to the week being changed. **Failure to give notification at least two weeks prior to the changed week will result in having to pay the full camp fee.**

Please check the WEEKLY box to sign up for direct withdrawal, where the above card number will be charged on each Thursday two weeks prior to the week of attendance. ***DEPOSIT: One week of camp tuition per child***

☐ **WEEKLY (Please check for direct withdrawal)**

By signing this form, you are giving permission to the Bexley Recreation Department to charge the above listed credit card and/or account number the amount owed each week for Jeffrey Summer Camp. All late fees, cancellation charges, and outstanding payments will be assessed to this card. Payment for any other Bexley Recreation sponsored program may NOT be charged as a result of this form.

Signature: _____ **Date:** _____

Week Attending	Account to be Charged on:
Week 1: May 31 – June 3*	Thursday, May 19, 2016
Week 2: June 6 – June 10	Thursday, May 26, 2016
Week 3: June 13 – June 17	Thursday, June 2, 2016
Week 4: June 20 – June 24	Thursday, June 9, 2016
Week 5: June 27 – July 1	Thursday, June 16, 2016
Week 6: July 5 – July 8	Thursday, June 23, 2016
Week 7: July 11 – July 15	Thursday, June 30, 2016
Week 8: July 18 – July 22	Thursday, July 7, 2016
Week 9: July 25 – July 29**	Thursday, July 14, 2016
Week 10: August 1 – August 5	Thursday, July 21, 2016
Week 11: August 8 – August 12	Thursday, July 27, 2016
Week 11 ½ : Aug.15 – Aug.16 *($70)*	Thursday, August 3, 2016

***Prorated**

****Last Week Of Adventure, Over-Night White Water Rafting, $200.***

Revised January 16