



Bexley Recreation & Parks

2016-17 School's Off- Camp's On Registration Form



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

<input type="checkbox"/> K – 3 rd Grade Located at Maryland Elementary	<input type="checkbox"/> 4 th – 6 th Grade Located at Maryland Elementary
--	--

Please print clearly in all sections.

Child's Name _____ DOB ____/____/____ Age ____ Sex ____ Grade (2016-17) ____

Parent/Guardian's Name _____ Address _____

Email _____ Phone: Home _____ Work _____ Cell _____

Other parent/guardian (if different than above)

Parent/Guardian's Name _____ Address _____

Email _____ Phone: Home _____ Work _____ Cell _____

REGISTRATION / PAYMENT POLICY

Payment for individual school days must be made in full at the time of registration. Payment for camp weeks (i.e. Winter Break, Spring Break) must be made in full by the Wednesday prior to the start of that week. Credit Card must be put on file to make payments as well as cancellation charges.

CANCELLATION POLICY

There will be **NO** cancellation fee for cancellation of days/weeks made at or prior to the first day of school on Wednesday, August 17th. Cancellations made after the first day of school will include a \$10 cancellation fee for each day of cancellation. Cancellations for camp weeks (i.e. Winter Break, Spring Break) must be made two weeks prior to the week of attendance and will incur a \$25 cancellation fee. Any cancellation made inside of two weeks will result in a full charge for the week. Parents must notify in writing to the Camp Administrator of withdrawal by two weeks prior to the week/day 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.

<u>(Yes / No)</u>	<u>Dates</u>	<u>Location</u>	<u>Time</u>	<u>Cost</u>	<u>T-Shirt Size</u>
<input type="checkbox"/> Day 1	Sept. 5 (Labor Day)	Schools	7am – 6pm	\$35	Youth:
<input type="checkbox"/> Day 2	Oct. 3 (Rosh Hashanah)	Schools	7am – 6pm	\$35	S: <input type="checkbox"/>
<input type="checkbox"/> Day 3	Oct. 12 (Yom Kippur)	Schools	7am – 6pm	\$35	M: <input type="checkbox"/>
<input type="checkbox"/> Day 4	Oct. 21 (Conferences)	Schools	7am – 6pm	\$35	L: <input type="checkbox"/>
<input type="checkbox"/> Day 5	Nov. 7 (Staff In-Service)	Schools	7am – 6pm	\$35	Adult:
<input type="checkbox"/> Day 6	Nov. 8 (Staff In-Service)	Schools	7am – 6pm	\$35	S: <input type="checkbox"/>
<input type="checkbox"/> Day 7	Nov. 23 (Conferences)	Schools	7am – 6pm	\$35	M: <input type="checkbox"/>
<input type="checkbox"/> Day 8	Dec. 22 (Winter Break)	Schools	7am – 6pm	\$35	L: <input type="checkbox"/>
<input type="checkbox"/> Day 9	Dec. 23 (Winter Break)	Schools	7am – 6pm	\$35	XL: <input type="checkbox"/>
<input type="checkbox"/> Day 10	Jan. 2 (Winter Break)	Schools	7am – 6pm	\$35	
<input type="checkbox"/> Day 11	Jan. 16 (M.L. King, Jr. Day)	Jeffrey Mansion	7am – 6pm	\$35	
<input type="checkbox"/> Day 12	Feb. 20 (Presidents' Day)	Jeffrey Mansion	7am – 6pm	\$35	
<input type="checkbox"/> Day 13	April 14 (Good Friday)	Schools	7am – 6pm	\$35	
<input type="checkbox"/> Full Day Package*	(All 13 Days listed above)			\$385 (\$70 Savings)	

*Purchase of the Full Day Package gives you 13 days at the price of 11 days

<u>Weeks</u>	<u>Dates</u>	<u>Location</u>	<u>Time</u>	<u>Cost</u>
<input type="checkbox"/> Winter Break	Dec. 26 – Dec. 30	Schools	7am – 6pm	\$165
<input type="checkbox"/> Spring Break	March 20 – March 24	Schools	7am – 6pm	\$165
<input type="checkbox"/> Complete Year Coverage**				\$685 (\$100 Savings)

**This option provides coverage for all 13 days as well as Winter Break and Spring Break

If the child registered on this form was a 2016 Jeffrey Summer Camp Program (JSCP) or School Before/After Care Program participant, by checking this box, you give us permission to use the 2016 JSCP forms (Permission/Photo Release, Dismissal, & Medical Forms) as the official School's Off – Camp's On Forms. The only other form you would need to fill out is the payment form.

I give permission for my child to participate in swim time while at camp. Yes No If No, Please Explain: _____

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/School Days Off-Camp is On 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. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> 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 <u>at least one person</u> 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? <input type="checkbox"/> Yes (If yes, skip to Emergency Transportation Authorization section) <input type="checkbox"/> 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:
<input type="checkbox"/> I agree with the program's schedule <input type="checkbox"/> I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

<u>Give Permission to Transport</u>	OR	<u>Do Not Give Permission to Transport</u>
Center or Type A Home Name	Do not sign both	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.		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 (<i>print or type</i>)	Date of Birth
<input type="checkbox"/> 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

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

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lead	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemoglobin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

<u>Check all that apply:</u>	
<input type="checkbox"/> Prescription medication	<input checked="" type="checkbox"/> Topical product or lotion
<input type="checkbox"/> Nonprescription medication	<input type="checkbox"/> Food supplement
<input type="checkbox"/> Refrigeration required	<input type="checkbox"/> Modified diet
<u>Complete all of the following information:</u>	
Name of child: _____	Date of birth: _____ Weight: _____
Name of medication: <u>Hand Sanitizer</u>	Exact dosage: <u>1 Pump</u>
To be administered at the following times <u>Before Eating</u>	
For the following period of time: <u>While Attending Camp</u>	
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 applied longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated) or food supplement; 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 OAC rules 5101:2-12-31 and 5101:2-13-31



Bexley Recreation & Parks

2016-17 School's Off- Camp's On Dismissal Form



***Please select the grade for each child.**

The following persons have my permission to pick up my child(ren) from School's Off – Camp's On. I understand my child(ren) will not be released without a picture ID. PARENTS NEED TO BE INCLUDED ON THIS LIST!

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

Name of Child/Children:

1. _____	<input type="checkbox"/> K – 3 rd Grade Located at Maryland Elementary	<input type="checkbox"/> 4 th – 6 th Grade Located at Maryland Elementary
2. _____	<input type="checkbox"/> K – 3 rd Grade Located at Maryland Elementary	<input type="checkbox"/> 4 th – 6 th Grade Located at Maryland Elementary
3. _____	<input type="checkbox"/> K – 3 rd Grade Located at Maryland Elementary	<input type="checkbox"/> 4 th – 6 th Grade Located at Maryland Elementary
4. _____	<input type="checkbox"/> K – 3 rd Grade Located at Maryland Elementary	<input type="checkbox"/> 4 th – 6 th Grade Located at Maryland Elementary

Name of Authorized Person(s)

Relationship to Child

1. _____	_____ parent/guardian _____
2. _____	_____ parent/guardian _____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Parent Name: _____

Parent Signature: _____ Date: _____

Comments:



2016-17 School's Off- Camp's On Permission/Photo Release Form



***Please select the grade for each child.**

Name of Child/Children:

1. _____

<input type="checkbox"/> K – 3 rd Grade Located at Maryland Elementary	<input type="checkbox"/> 4 th – 6 th Grade Located at Maryland Elementary
--	--

2. _____

<input type="checkbox"/> K – 3 rd Grade Located at Maryland Elementary	<input type="checkbox"/> 4 th – 6 th Grade Located at Maryland Elementary
--	--

3. _____

<input type="checkbox"/> K – 3 rd Grade Located at Maryland Elementary	<input type="checkbox"/> 4 th – 6 th Grade Located at Maryland Elementary
--	--

4. _____

<input type="checkbox"/> K – 3 rd Grade Located at Maryland Elementary	<input type="checkbox"/> 4 th – 6 th Grade Located at Maryland Elementary
--	--

Parent/Guardian's Name _____ Best Available # _____ # _____

Secondary Contact _____ Best Available # _____ # _____

Transportation by the Bexley City Schools or other Certified Transportation Company

The field trips will be scheduled and publicized as soon as set. There will be one trip scheduled for each week, however all trips are subject to change. This permission slip covers all scheduled trips for School's Off-Camp's On program.

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.

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.

Parent/Guardian's Name _____

(Please Print)

Parent/Guardian's Signature _____ Date _____

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.

<u>Check all that apply:</u>	
<input type="checkbox"/> Prescription medication	<input type="checkbox"/> Topical product or lotion
<input type="checkbox"/> Nonprescription medication	<input type="checkbox"/> Food supplement
<input type="checkbox"/> Refrigeration required	<input type="checkbox"/> Modified diet
<u>Complete all of the following information:</u>	
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 applied longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated) or food supplement; 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 OAC rules 5101:2-12-31 and 5101:2-13-31

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 <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

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.



Bexley Recreation & Parks

2016-17 School's Off – Camp's On Deposit & Direct Withdraw Form



Name of Child/Children: _____

1.

<input type="checkbox"/> K – 3 rd Grade Located at Maryland Elementary	<input type="checkbox"/> 4 th – 6 th Grade Location at Maryland Elementary
--	---

2.

<input type="checkbox"/> K – 3 rd Grade Located at Maryland Elementary	<input type="checkbox"/> 4 th – 6 th Grade Location at Maryland Elementary
--	---

3.

<input type="checkbox"/> K – 3 rd Grade Located at Maryland Elementary	<input type="checkbox"/> 4 th – 6 th Grade Location at Maryland Elementary
--	---

4.

<input type="checkbox"/> K – 3 rd Grade Located at Maryland Elementary	<input type="checkbox"/> 4 th – 6 th Grade Location at Maryland Elementary
--	---

Name on Card: _____ Credit Card Type: VISA MC

Account # _____ - _____ - _____ / _____ : _____

***Please check Deposit and/or Daily/Weekly for direct withdrawal

****Payment for all individual days will be charged to the cards on Thursday, August 18, 2016. Payment for all weeks will be charged to the card the Thursday prior to that week.

DEPOSIT **\$290 Per Family (not charged)** DAILY/WEEKLY (Please check for direct withdrawal)

By signing this form, you are giving permission to the Bexley Recreation Department to charge to the above listed credit card and/or account number the amount owed each day/week for School's Off – Camp's On. 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: _____

REGISTRATION / PAYMENT POLICY

Payment for individual school days must be made in full at the time of registration. Payment for camp weeks (i.e. Winter Break, Spring Break) must be made in full by the Wednesday prior to the start of that week. Credit Card must be put on file to make payments as well as cancelation charges.

CANCELLATION POLICY

There will be **NO** cancellation fee for cancellation of days/weeks made at or prior to the first day of school on Wednesday, August 17th. Cancellations made after the first day of school will include a \$10 cancellation fee for each day of cancellation. Cancellations for camp weeks (i.e. Winter Break, Spring Break) must be made two weeks prior to the week of attendance and will incur a \$25 cancellation fee. Any cancellation made inside of two weeks will result in a full charge for the week. Parents must notify in writing to the Camp Administrator of withdrawal by two weeks prior to the week/day 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.