Summer Camp **Shepherd's Gate Registration** **July 1st – August 16th**

1725 Brentwood Rd, Brentwood NY 1171

(631) 435-3215 www.shepherdsgateacademy.com **Date____/_____/2024**

Parent Information

Parent/Guardian 1	Parent/Guardian 2
Mother's Full Name/Nombre Completo de Madre:	Father's Full Name/Nombre Completo de Papa:
Mother's Cell Phone/ Celular de Madre: ( )	Father's Cell Phone/ Celular de Padre: ( )
Mother's Employer/ Empleador de Madre:	Father's Employer/ Empleador de Papa:
Position/Posicion:	Position/Posicion:
Mother's work Phone/Telefono de Trabajo de Mama: **( )**	Father's Work Phone/Telefono de Trabajo de Papa: **( )**
Mother's Email/ Correo Electronico de Mama:	Father's Email/ Correo Electronico de Papa:
Address/Direccion:	
Parent: Private ☐ DSS Approved ☐ DSS Applying ☐ 1199 ☐ Scholarship ☐ Other ☐	

If Parents are Separated or Divorced with whom does the child live? _____

Enrollment - July +August

Summer Camp Weeks Desired

Child's Name Nombre del Nino/a	D.O.B	Gender Genero	Age Edad	All 7 Weeks	1	2	3	4	5	6	7

Emergency Contacts

Name	Phone Number	Relationship/Relacion	Allowed to remove premises? Autorizado a llevarse Nino/a
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
Physician		Doctor	Yes ☐ No ☐

Confirmation of Summer Camp week will be provided only after full payment is received. Guarantee of weeks is assured only on a first-paid first-reserved basis. Every child must pay a non-refundable registration fee of $200. After a week is paid for, that week belongs to the parent/guardian and the paid tuition thereof is not refundable.

Please check one & Initial: Yes ☐ _____ No ☐ _____ I give permission for pictures to be taken for use by Shepherd's Gate to be displayed in yearbooks, brochures and website purposes, not to be shared with any outside organization

How Did you hear about us? _____

Has your child attended any other Shepherd's gate program? _____

Summer Camp **Shepherd's Gate Registration** **July 1st – August 16th**

1725 Brentwood Rd, Brentwood NY 1171

(631) 435-3215 www.shepherdsgateacademy.com **Date____/_____/2024**

Charges- Internal Use Only	**Amount Due**		**Paid Enter**		**Office use only Weeks reserved**
Non-refundable Registration Fee Number of children: _____ x $200.00 =					Excel ☐ Procare ☐ File ☐____
School Age-Full Day 5-12 years 1st Child: $250 x weeks ___ = 2nd Child: $240 x weeks___ =					
School Age- Half day 5-12years 1st Child: $150 x weeks ___ = 2nd Child: $150 x weeks___ =					**(Please Check Program)** **AM- 9:00 AM-12 PM ☐** **PM- 1:00 PM-4:00 PM ☐**
Pre-K- Full Day 3.5-4.5 years 1st Child: $250 x weeks ___ = 2nd Child: $240 x weeks___ =					
Pre-K- Half Day 3.5-4.5years 1st Child: $150 x weeks ___ = 2nd Child: $150 x weeks___ =					**(Please Check Program)** **AM- 9:00 AM-12 PM ☐** **PM- 1:00 PM-4 PM ☐**
Full Day Daily Rate $65 X _____ Days X _____Weeks= $15 X _____ Trips=					**M T W Th F**
Extended hrs: before 9:00 AM **or** after 4:00 PM One Session (AM or PM) $60 x wks__ (per family) Both AM and PM: $100 x wks __ (per family) =					**AM Hours ☐** **PM Hours ☐ (Please Check)** **Both ☐**
T-SHIRTS S –M-L SIZE_____ #_____					**$15 PER SHIRTS**
Total					**Balance-**

Payment Arrangement: A Copy must be given to the client & Accounting Department Date:____/____/_____

Layaway Plan ☐ _____ Payment Plan ☐ _____ C.C/Cash/Check/Plan ☐ _____

Shepherd's Gate Personnel: _____ **Date: _____/____/_____**

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

TSHIRT ORDER: TOTAL $_____ PAID ON _____/_____/_____ STAFF INITIALS_____

Total # OF T-SHIRTS-_____ CXS____CS_____CM_____CL____CXL____ AS____AM____AL____AXL____

Summer Camp **Shepherd's Gate Registration** **July 1st – August 16th**

1725 Brentwood Rd, Brentwood NY 1171

(631) 435-3215 www.shepherdsgateacademy.com **Date____/_____/2024**

***Medical Alert*:**

Does your child have allergies? Y ☐ or N ☐. If yes, to what _____ Milk, eggs, bee sting, peanuts, etc.

What precautions should be observed? _____

Please clearly state any dietary restrictions. _____

Is your child on daily medication? Y ☐ or N ☐ if yes, please describe medication and regime (Ritalin, insulin, etc.)

Fully describe in writing any physical or emotional limitations: _____

_____

***Medical Emergency*:** In case of injury or illness to my child, if I cannot be contacted, I hereby grant Shepherd's Gate permission to seek and apply medical aid appropriate to prudent care, this includes calling 911 for proper care if required

X_____

Statement of Cooperation

It is my understanding that the policy for Shepherd's Gate is to make no refunds on registration fees. I give Shepherd's Gate permission for my child to take part in all school activities, including bus trips, sports activities and school-sponsored trips away from the school premises. I further agree to hold the school and its agents harmless for any liability to my child or any guardian or parent thereof because of any claims on behalf of my child be taken against Shepherd's Gate or any employee or agent thereof, on my child's behalf and the school or its agent not be found at fault, I agree to pay any attorney fees, court fees, damages or other costs that Shepherd's Gate or its agent should incur to defend itself against such action.

This Statement of Cooperation will be in effect for as long as my children listed (or others to be enrolled) attend Shepherd's Gate Summer Camp.

I understand that should my marital status change that it is my responsibility to have a corrected Statement of Cooperation signed and updated and delivered to Shepherd's Gate. Shepherd's Gate admits children of any race, color, religion, and national or ethnic origin.

Mother: _____ Father: _____

Guardian: _____ Date: _____/_____/_____

****Signature for statement of cooperation Required****

Late Fee: I understand that there is a $1 per minute late fee for lateness after 4 PM if late pick up has not been prearranged

x_____

Registration Orientation Checklist: For Office Use Only

S.G News Subscription _____ Website Membership _____ Camp Info Packet & Calendar_____

Payment Information _____ Camp Policies _____ Staff Initials _____

Dss case worker _____ Weekly Parent Fee: $_____ if you need Before /After Care you are able to only select either AM or PM . if you need both Before/Aftercare you must pay $60 per week.

Phone Numer: ( )

Coverage Start: Day_____/_____/_____ End Day:_____/_____/_____

Summer Camp **Shepherd's Gate Registration** **July 1st – August 16th**

1725 Brentwood Rd, Brentwood NY 1171

(631) 435-3215 www.shepherdsgateacademy.com **Date____/_____/2024**

Field Trip Transportation Agreement

I, _____ , give permission for my child care provider, or any approved
(Name of parent)

employee of the above program, to transport my child(ren)

1._____ 2._____ 3._____
(Name(s) of child(ren) (Name(s) of child(ren) (Name(s) of child(ren)

for the following field trips (Please Initial Below): Trip dates are subject to change due to weather or other circumstance.

Parent Initials	Date	Trip
_____	_____	- TRIP TBD
_____	_____	- TRIP TBD
_____	_____	- TRIP TBD
_____	_____	- TRIP TBD
_____	_____	- TRIP TBD
_____	_____	- TRIP TBD

It is agreed that:

1. The caregiver will never leave my child(ren) unattended in any motor vehicle or other form of transportation.
2. Each child will board or leave a vehicle from the curb side of the street.
3. My child(ren) will be secured in safety seats or by safety belts as appropriate for the age of the child(ren) in accordance with the law.
4. Any motor vehicle used to transport my child(ren) will have current registration and inspection stickers, and must be operated by a person who is at least 18 years of age and possesses a valid driver's license.
5. Staff to child ratios will be maintained throughout the course of the trip. The driver of the bus will not be considered as part of the ratios.

_____ _____ /_____ /_____
(Parent or Guardian) (Date)

Sunscreen Permission

The child care provider or her substitutes have my permission to apply sunscreen to my child _____, as needed. I understand I am still responsible for sending my child with Sunscreen already applied daily.

My signature below signifies that I am aware of and agree with the provider's policy of applying sunscreen as needed, and that I am still responsible for applying it to my child prior to drop off every day during the months needed.

_____ _____/_____/_____
(Parent or Guardian) (Date)

_____ _____/_____/_____
(Office Personnel) (Date)

Summer Camp **Shepherd's Gate Registration** **July 1st – August 16th**

1725 Brentwood Rd, Brentwood NY 1171

(631) 435-3215 www.shepherdsgateacademy.com **Date____/_____/2024**

PRIVATE PHYSICIAN'S REPORT

OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

DATE _____ 20 ____

NAME OF SCHOOL _____ GRADE HOMEROOM _____

NAME OF CHILD			DATE OF BIRTH	SEX
				☐ M ☐ F
Last	First	Middle		

ADDRESS

No. and Street	City or Post Office	Borough or Township	County	State	Zip Code

MEDICAL HISTORY
IMMUNIZATIONS AND TESTS

VACCINE	Enter Month, Day, And Year Each Immunization Was Given DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 /	3 /	4 /	5 /
Measles, Mumps, Rubella	1 / /	/2 /	/ /		
Hepatitis B	1 / //	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	Varicella Disease or Lab Evidence Date: _____		
Other _____					

☐ MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health RELIGIOUS
☐ EXEMPTION (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

If Applicable:

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	**Results (mm)**		**Signature**		

Follow-Up of significant tuberculin tests:
Parent/Guardian notified of significant findings on _____.
Date

Result of Diagnostic Studies: _____.
Date

Preventive Anti-Tuberculosis - Chemotherapy ordered. No ☐ Yes ☐ _____

Summer Camp

Shepherd's Gate Registration

July 1st – August 16th

1725 Brentwood Rd, Brentwood NY 1171

(631) 435-3215 www.shepherdsgateacademy.com **Date____/_____/2024**

Significant Medical Conditions

	Yes	No	If Yes, Explain
Allergies.....	☐	☐	_____
Asthma.....	☐	☐	_____
Cardiac.....	☐	☐	_____
Chemical Dependency.....	☐	☐	_____
Drugs.....	☐	☐	_____
Alcohol.....	☐	☐	_____
Diabetes Mellitus.....	☐	☐	_____
Gastrointestinal Disorder.....	☐	☐	_____
Hearing Disorder.....	☐	☐	_____
Hypertension.....	☐	☐	_____
Neuromuscular Disorder.....	☐	☐	_____
Orthopedic Condition.....	☐	☐	_____
Respiratory Illness.....	☐	☐	_____
Seizure Disorder.....	☐	☐	_____
Skin Disorder.....	☐	☐	_____
Vision Disorder.....	☐	☐	_____
Other (Specify).....	☐	☐	_____

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

• Height (inches)				
• Weight (pounds) BMI				
• Pulse ( )				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes/Vision				
• Ears/Hearing				
• Nose and Throat				
• Teeth and Gingiva				
• Lymph Glands				
• Heart — Murmur, etc.				
• Lung — Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

_____
Date of Examination

_____ _____
Signature of Examiner **Print** Name of Examiner

_____ _____
Address Telephone Number

Automated Payment Processing

Procare SOLUTIONS

Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

Childs Name: _____

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

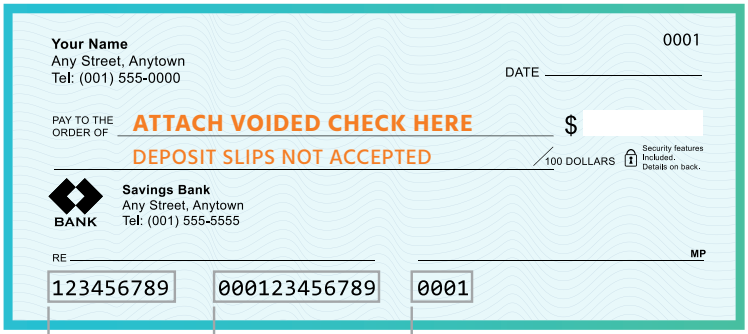
Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____



FOR OFFICIAL USE ONLY

Date Received

Employee Signature

800.338.3884 • procaresoftware.com