YMCA CAMP TWIN LAKES
2017 OVERNIGHT SUMMER CAMP

Please complete this form and return with the appropriate deposit (non-refundable, non-transferable) see below. Mail to: Camp Twin Lakes; 204 E. Little Elm Trl, Cedar Park, TX 78613 or bring to any Williamson County YMCA branch. For questions regarding Camp Twin Lakes please call 512-257-0709.

CAMPER

Camper's first name | Middle initial | Last name

Gender ☐ boy ☐ girl | Date of birth | Grade in fall | Age at camp

Camper's address | City | State | ZIP code

PARENT / GUARDIAN

Parent/guardian name | Email

Home phone | Day phone | Cell phone

Other parent/guardian name | Email

Home phone | Day phone | Cell phone

AUTHORIZED PICKUPS

Local person to call in case of emergency if parent/guardian cannot be reached (authorized to release child to)

Name | Phone | Alternate phone

In addition; I hereby authorize the Y staff to allow my child to be released to the following persons:

Name | Phone | Alternate phone

Name | Phone | Alternate phone

Name | Phone | Alternate phone

CABIN MATE REQUEST

Name

One request per camper, please.
Cabin mate requests must appear on both campers registrations and both campers must be in the same age grouping. Requests are not guaranteed. We reserve the right to separate groups of more than 3 campers to facilitate new group/cabin friendships. Cabins are grouped in Villages by age, so campers of the same age but not sharing the same cabin are in the same Village.

OVERNIGHT SESSION INFO (Full week • Sunday thru Friday)

Choose session(s): ☐ **week 2**: June 11 – 16 ☐ **week 3**: June 18 – 23 ☐ **week 4**: June 25 – June 30
☐ **week 6**: July 9 – 14 ☐ **week 7**: July 16 –21 ☐ **week 8**: July 23 –28

Choose fee: ☐ **Y Member**: $649
☐ **Non-Members**: $724

MINI OVERNIGHT SESSION INFO

2 NIGHTS & 7 MEALS (begins lunch Wednesday to Dinner Friday)

Choose Date: ☐ **week 5**: July 5 – 7

Choose Fee: ☐ **Y Member**: $335 ☐ **Non-Members**: $370
(includes Monday Day Camp)

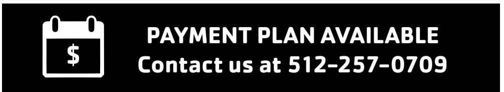
Choose Date: ☐ **week 9**: August 2 – 4 ☐ **week 10**: August 9 – 11

Choose Fee: ☐ **Y Member**: $375 ☐ **Non-Members**: $399
(includes Monday & Tuesday Day Camp)

Fee: (from overnight and/or mini session)	
Trading Post Account: (optional/$20 to $30 recommended per session)	
TOTAL	
Less amount to be paid today	
Balance Due (to be paid in full two weeks prior to camp)	

Registration requires a Minimum Deposit which is a part of the Camp Fee. $100 per week, NON-REFUNDABLE.

YMCA Member Branch | **Location**



YMCA CAMP TWIN LAKES
2017 OVERNIGHT SUMMER CAMP

Camper's First name	Middle initial	Last name

PARENT / GUARDIAN ACKNOWLEDGEMENTS

please INITIAL all lines to indicate received written policies / materials and agree to terms.

_____ ADA Policy (REQUIRED): Parents have the obligation to disclose significant, medical, physical or behavioral issues at the time of the child's enrollment and on an ongoing basis. Due to the large group format of our program, we are unable to provide one-on-one care for any child except on an intermittent basis, such as injuries, immediate disciplinary issues and certain personal care needs customarily provided to other children.

_____ Permission for Transportation (REQUIRED): I grant permission for the Y staff to transport my child to and from his / her Elementary School or other Y camp site for field trips and other planned events. I understand that all reasonable precautions will be taken to ensure the safety and health of my child.

_____ Waiver for Medical Treatment (REQUIRED): In the event that my child requires emergency medical treatment and I cannot be reached, I hereby authorize the Y staff to make arrangements to transport my child to the physician, hospital or clinic that I have designated or the nearest hospital / emergency medical facility. I give my consent for any and all necessary medical care treatment for my child during this time.

_____ Waiver for Participation (REQUIRED): I understand that Y activities have inherent risks and hereby assume all risks and hazards as a result of my child's participation in all Y programs and facilities, including transportation to and from said activities. I further release, absolve, indemnify and agree to hold harmless, the Y, the organizers, supervisors, directors, staff, volunteers, participants, coaches, referees, as well as persons or parents transporting participants to or from such activities from any claims or injury sustained during my use of Y facilities or participation in any Y activity, whether located on Y property or not.

_____ Policy Agreement (REQUIRED) I acknowledge that I have received a copy of the Y Family Guide (should my selected camp provide one). I also accept responsibility to read and adhere to the billing procedures and all policies as set forth in the Family Guide or by my selected camp.

_____ Refund / Transfer Policy Agreement (REQUIRED): A $10 processing fee will be applied for all drops or transfers for each child.

_____ Waiver for Photo/Video Release (OPTIONAL): I give my consent for any photos or videos taken of my child involved in Y programs to be used for Y promotions, trainings or displays.

Signature of parent / guardian

DISCIPLINE & GUIDANCE POLICY

Discipline must be:

1. Individualized and consistent for each child
2. Appropriate to the child's level of understanding
3. Directed toward teaching the child acceptable behavior and self-control

A caregiver may only use positive methods of discipline and guidance that encourage self-esteem, self-control and self-direction, which include at least the following:

1. Using praise and encouragement of good behavior instead of focusing only upon unacceptable behavior
2. Reminding a child of behavior expectations daily by using clear, positive statements
3. Redirecting behavior using positive statements
4. Using a brief cooling off period when appropriate; which is limited to the child's decision to rejoin the group

There must be no harsh, cruel or unusual treatment of any child. The following types of discipline and guidance are prohibited:

1. Corporal punishment or threats of corporal punishment
2. Punishment associated with food, quiet time or bathroom use
3. Pinching, shaking or biting a child
4. Hitting a child with a hand or instrument
5. Putting anything in or on a child's mouth
6. Humiliating, ridiculing, rejecting or yelling at a child
7. Subjecting a child to harsh, abusive or profane language
8. Placing a child in a locked or dark room, bathroom or closet with the door closed
9. Requiring a child to remain silent or inactive for inappropriate periods of time

Parent / Guardian Acknowledgement
My signature verifies that I have read and received a copy of this discipline and guidance policy.

Signature of parent / guardian	Printed name	Date

TO PARENT OR GUARDIAN

TO PARENT OR GUARDIAN: Please check the registration information for accuracy. Please read the following statement and sign at the point indicated below. "Admission as a camper to Camp Twin Lakes carries many privileges and responsibilities. Campers are expected to participate in the total life of camp: to work, play and live together. Camp Administration does not allow the use of tobacco, alcohol, illegal drugs or weapons. Registration application signifies my understanding and acceptance of these responsibilities – violators will be dismissed without a refund. In addition, should a behavior or discipline problem affect work with other campers or their enjoyment of Camp Twin Lakes, CAMP ADMINISTRATION RESERVES THE RIGHT TO DISMISS THOSE CAMPERS RESPONSIBLE, WITHOUT A REFUND. In the event of the withdrawal or dismissal from camp for any other reason than illness requiring the attention of a physician, I will pay the camp fee in full. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp administrator to hospitalize, secure proper treatment of, and to order injection, anesthesia or surgery for my child as named above. I will notify the Camp Director if my child has any serious restrictions related to his/her participation in the camp program. I also understand that the YMCA of Greater Williamson County and its Camping Services Branch assume no responsibility for accidental injury to my child during his/her stay at the camps."

Signature of parent / guardian

YMCA OF GREATER WILLIAMSON COUNTY SUMMER CAMP AGREEMENT ACH/CC/DEBIT AUTOMATIC PAYMENT OPTION

1. INFO

Camper's first name | Middle initial | Last name

Camper's address | City | State | ZIP code

Home phone | Day phone | Cell phone

2. BEGIN DRAFT DATE

Begin draft date ______ / ______ / ______

3. DRAFT SCHEDULE

Draft date	May 15		Jun 1		Jun 15		Jul 1		Jul 15		Aug 1	
Week #	0	1	2	3	4	5	6	7	8	9	10	11
Service Dates	May 29–Jun 2	Jun 5–9	Jun 12–16	Jun 19–23	Jun 26–30	Jul 3–7	Jul 10–14	Jul 17–21	Jul 24–28	Jul 31–Aug 4	Aug 7–11	Aug 14–18
Balance amount												

4. BANK / CREDIT / DEBIT DRAFT AGREEMENT

☐ OPTION 1: CREDIT / DEBIT CARD

Please check one: ☐ visa ☐ mastercard ☐ discover

Credit / debit card # | Exp. date

Cardholder name | CVV

☐ OPTION 2: BANK DRAFT

Account holder name | Bank name

Routing / transit # | Bank account #

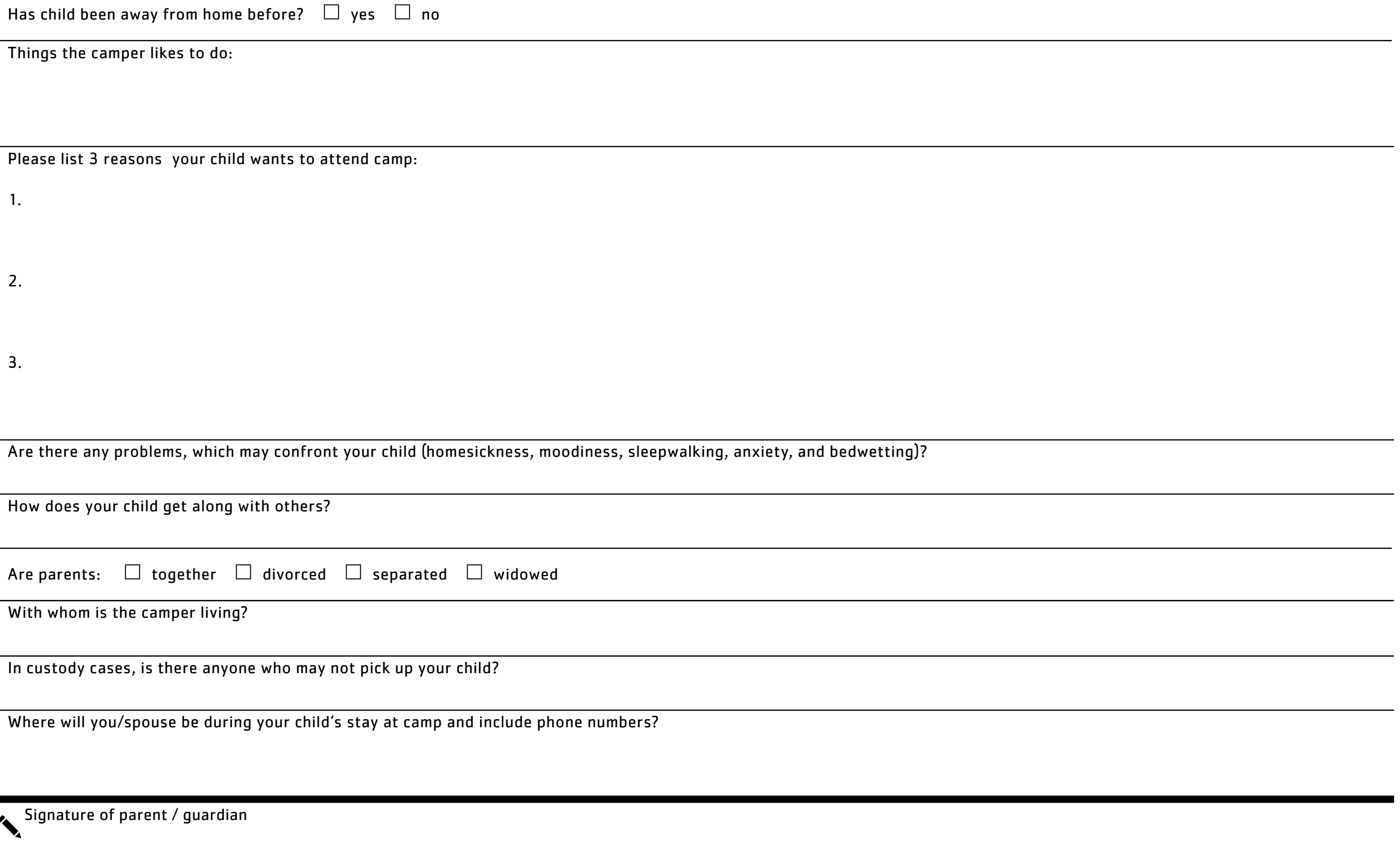
- ✔ Only 1 Form of Draft Payment can be entered per person.
- ✔ Children enrolled in Y Afterschool may have a larger draft amount on May 15 & Aug 1.

1. Summer Camp auto-drafts occur twice a month (1st and 15th) for two camp weeks at a time, depending on which camp weeks are selected. Refer to Step #3 above.
2. I understand that should I choose to terminate or change Bank Accounts, Banks, Account Types or Child Care Plan in anyway, I must provide the Y with at least a 2 week written notice prior to my transfer date.
3. I understand that the information above will be used to transfer payment from my account.
4. I understand that if my payment is returned for non-sufficient funds (NSF) for any reason, the item(s) will be re-presented electronically and I understand I will be charged a $30 non-sufficient funds (NSF) processing fee. I am also responsible for all other recovery costs.
5. I understand that if my account has a late pick up fee or late payment fee, the amount will be drafted from my account on the next draft date.
6. The Y only accepts Visa, MasterCard and Discover.
7. I understand that after three returned items, I will be ineligible to use the automatic payment option. My account will then become cash or money order only.

Signature | Date

YMCA CAMP TWIN LAKES
2017 OVERNIGHT SUMMER CAMP

PARENT–CAMPER CONFIDENTIAL FORM



CAMPER

Camper's name Nickname

Date of birth | Age | Grade next fall | School

Address | City | State | ZIP code

Number of siblings | Age of siblings

QUESTIONS

Has child been away from home before? ☐ yes ☐ no

Things the camper likes to do:

Please list 3 reasons your child wants to attend camp:

1.

2.

3.

Are there any problems, which may confront your child (homesickness, moodiness, sleepwalking, anxiety, and bedwetting)?

How does your child get along with others?

Are parents: ☐ together ☐ divorced ☐ separated ☐ widowed

With whom is the camper living?

In custody cases, is there anyone who may not pick up your child?

Where will you/spouse be during your child's stay at camp and include phone numbers?

Signature of parent / guardian

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Mail this form to the address below by _______ (date)

Dates will attend camp: from ______________ to ______________
Month/Day/Year Month/Day/Year

Camper Name: ____
First Middle Last

☐ Male ☐ Female Birth Date ____________ Age on arrival at camp: ________
Month/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1) ***Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.***
2) ***Send the original, signed FORM 1 to camp by the requested date.***
3) ***Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.***
4) ***After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.***

Camper Name ______________________ First Middle Last

(For Camp Use) Cabin or Group ______________

(For Camp Use) Session Code(s): ______________

Camper Home Address: ____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: ______________________ Relationship to Camper: ______________ Preferred Phones: (______) ______________ (______) ______________

Email: ______________________

Home Address: ____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: ______________________ Relationship to Camper: ______________ Preferred Phones: (______) ______________ (______) ______________

Email: ______________________

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): ______________________ Relationship to Camper: ______________ Preferred Phones: (______) ______________ (______) ______________

Allergies: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet.
☐ This camper has special food needs. ***(Please describe below.)***

Restrictions: ☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. ***(Please describe below.)***

Medical Insurance Information:

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company ______________________ Policy Number ______________________

Subscriber ______________________ Insurance Company Phone Number (______) ______________

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian ______________________ Date: ______________ Relationship to Camper: ______________

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: ______________________________________
First Middle Last

Birth Date: ____________
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis★ (DTaP) or (TdaP)						
Tetanus booster★ (dT) or (TdaP)						
Mumps, measles, rubella★ (MMR)						
Polio★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative ☐ Positive

If your camper has not been fully immunized, please sign the following statement: **I understand and accept the risks to my child from not being fully immunized.**

Signature of Custodial Parent/Guardian: ______________________________ Date: ____________ Relationship to Camper: ________________

Medication: ☐ This camper will not take any daily medications while attending camp.

☐ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:__________		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:__________		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:__________		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

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CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: ______________________________
First Middle Last

Birth Date: ____________
Month/Day/Year

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

1. Ever been hospitalized? .... ☐ Yes ☐ No
2. Ever had surgery? .... ☐ Yes ☐ No
3. Have recurrent/chronic illnesses? .... ☐ Yes ☐ No
4. Had a recent infectious disease? .... ☐ Yes ☐ No
5. Had a recent injury? .... ☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath?...... ☐ Yes ☐ No
7. Have diabetes? .... ☐ Yes ☐ No
8. Had seizures? .... ☐ Yes ☐ No
9. Had headaches? .... ☐ Yes ☐ No
10. Wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No
11. Had fainting or dizziness? .... ☐ Yes ☐ No
12. Passed out/had chest pain during exercise? .... ☐ Yes ☐ No
13. Had mononucleosis ("mono") during the past 12 months?... ☐ Yes ☐ No
14. If female, have problems with periods/menstruation?......... ☐ Yes ☐ No
15. Have problems with falling asleep/sleepwalking? .... ☐ Yes ☐ No
16. Ever had back/joint problems?................................ ☐ Yes ☐ No
17. Have a history of bedwetting?................................ ☐ Yes ☐ No
18. Have problems with diarrhea/constipation?..................... ☐ Yes ☐ No
19. Have any skin problems?................................ ☐ Yes ☐ No
20. Traveled outside the country in the past 9 months?............. ☐ Yes ☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? .... ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?................................ ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?................................ ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life?................................ ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): ______________________ Phone: (________) ______________

Name of dentist(s): ______________________ Phone: (________) ______________

Name of orthodontist(s): ______________________ Phone: (________) ______________

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program***. Attach additional information if needed.***

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

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Rev. 1/2007 LEE/EAW

CAMPER HEALTH-CARE RECOMMENDATIONS
by LICENSED MEDICAL PERSONNEL FORM 2

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Mail this form to the address below by _______ (date)

***To Parent(s)/Guardian(s): Complete this section** and give **this form (FORM 2)** and **a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1)** to your child's health-care provider for review.*

Dates will attend camp: from _____________ to _____________
Month/Day/Year Month/Day/Year

Camper Name: ____
First Middle Last

☐ Male ☐ Female Birth Date ____________ Age on arrival at camp ________
Month/Day/Year

Camper home address: ____

____
City State Zip Code

Custodial parent(s)/guardian(s) phone: (_______)______________ (_______)____________

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

***Medical Personnel:** Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.*

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. ***Medical personnel:** Cross out those items the camper should not be given.*

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)
Chlorpheneramine maleate
Guaifenesin
Dextromethorphan
Diphenhydramine (Benadryl)
Generic cough drops
Chloraseptic (Sore throat spray)
Lice shampoo or scabies cream (Nix or Elimite)
Calamine lotion
Bismuth subsalicylate (Pepto-Bismol)
Laxatives for constipation (Ex-Lax)
Hydrocortisone 1% cream
Topical antibiotic cream
Calamine lotion
Aloe

Physical exam done today: ☐ Yes ☐ No (**If "No," date of last physical**: ___________)
Month/Day/Year

ACA accreditation standards specify physical exam within last 24 months.

Weight: _______ lbs Height: _____ft_____in Blood Pressure_______/_______

Allergies: ☐ No Known Allergies

☐ To foods ***(list):***

☐ To medications: ***(list):***

☐ To the environment ***(insect stings, hay fever, etc.– list):***

☐ Other allergies: ***(list):***

Describe previous reactions:

Diet, Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions: ***(describe below)***

The camper is undergoing treatment at this time for the following conditions: ***(describe below)*** ☐ None.

Medication: ☐ No daily medications. ☐ Will take the following prescribed medication(s) while at camp: ***(name, dose, frequency—describe below)***

Other treatments/therapies to be continued at camp: ***(describe below)*** ☐ None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes

If you answered "Yes" to the question above, what do you recommend? ***(describe below—attach additional information if needed)***

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print): ______________________ Signature: ______________________ Title: _________

Office Address____
Street City State Zip Code

Telephone: (________)_____________________ Date:______________________

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Camper Name ________________ First ________________ Middle ________________ Last ____ (For Camp Use) Cabin or Group____________ (For Camp Use) Session Code(s): ________