Camp Joy, PO Box 157, Clarksville, OH 45113
937-289-2031 e-mail: summercampregistrar@camp-joy.org
www.camp-joy.org

FOR OFFICE USE ONLY: Still Need _____
Notes:

2017 CAMP JOY POLICE YOUTH LIVE IN REGISTRATION FORM

We welcome participation of youth without regard to race, color, religion, sex, national origin, disability, ancestry, age, income eligibility, sexual orientation, or marital or family status.

PLEASE PRINT CLEARLY – *INCOMPLETE FORMS WILL NOT BE PROCESSED*

Camper's Name: Last _____ First _____ Circle One: M F Date of birth____/____/____

Street _____ City _____ State _____ Zip _____

Primary Phone (_____) _____ County_____ School District _____

Ethnicity (Optional – for statistical use only) Circle One: White African-Amer. Latino Asian Bi-Racial Other

Police/Youth Live-In Camp: June 19-23, 2017 (ages 10-12)

Please send this entire packet to Camp Joy

Payment

Registration is $25 per camper and must accompany this registration form to hold a space for your child.

Deadline is June 13th, 2017

☐ **Please pay with cash or check made out to Camp Joy** ☐ **Pay with credit card (see attached form)**

PARENT/GUARDIAN/FOSTER PARENT INFORMATION

1. Parent/Guardian's/Foster Parent's name____ Relationship _____
Home Address: Street _____ City _____ State _____ Zip _____
Home Phone (____) _____Cell Phone :(____) _____ Work Phone (____) _____
Email Address: _____ *Please circle Preferred correspondence*: **Email** or **Mail**

2. Parent/Guardian's/Foster Parent's name_____ Relationship _____
Home Address: Street _____ City _____ State _____ Zip _____
Home Phone (____) _____Cell Phone :(____) _____ Work Phone (____) _____

IF PARENT/GUARDIAN IS NOT AVAILABLE IN AN EMERGENCY NOTIFY: (List 2 contacts other than Parent/Legal Guardian)

1. Name _____Relationship _____ 2. Name _____Relationship _____
Home Phone (____)_____Cell/Work Phone (____)_____ Home Phone (____)_____Cell /Work Phone (____)_____

AUTHORIZATION FOR CAMPER PICK-UP Any additional persons to whom child may or may not be released:

☐ May_____ ☐ May not _____

AGENCY INFORMATION: Is this child affiliated with a foster care agency? Yes_____ No_____ (if yes—caseworker MUST sign below)
List any affiliated agency or service working with this child _____Contact/Social Worker _____
Phone #'s/Pagers 1.)_____ 2.) _____

TRANSPORTATION

Bus service is available from **Carl H. Lindner YMCA** located at 1425B Linn Street, Cincinnati, OH. 45214

REGISTRATION BEGINS MONDAY AT 11:30 AM.
- ☐ **Monday buses depart at 12:00pm**
- ☐ Will Drop My child of at Joy on Monday at **1:00pm**

BUS DROP-OFF IS FRIDAY AT 11 AM.
- ☐ **Friday Bus Transportation 11:00am**
- ☐ Will Pick up my child at Joy on Friday at **10:00am**

Acknowledgement of Risk and Release- Camp Joy

I understand that completing and signing this form is a prerequisite for my or my child's participation in Camp Joy's programs.

I understand that my participation in programs offered by Joy Outdoor Education Center, LLC (dba Camp Joy) and Joy Outdoor Education Center Foundation, Inc., is based on a "Challenge by Choice" philosophy. I recognize that the program is designed to use experiential, engaging, teaching techniques, but that my participation is purely voluntary, and I elect to participate in spite of the risks.

Activities: I am aware that experiential, outdoor pursuits for which I have enrolled such as living history reenactments (Ex. Underground Railroad), hiking, walking on uneven ground, high ropes challenge courses, ground initiatives, mountain biking, archery, swimming, and other activities at Camp Joy entail certain risks. Camp Joy has a number of high ropes elements. High ropes courses can include poles, ropes, cables and platforms on which participants move with and without the assistance of staff and other participants. The level of exertion required for the activities will be similar to a day of moderate to strenuous exercise. Activities are explained by staff, and belay or other support systems may be used. Activities vary in height and difficulty.

Risks: I understand and acknowledge that experiential education including high ropes courses and other Camp Joy activities involve risks which could result in injury, tripping, falling, broken bones, burns, death, or damage to my property. I may be in situations in which I depend on others for my physical well-being. The risks described and others are inherent in Camp Joy activities and without them the activities would lose their essential character and value.

Camp Joy recommends that those with heart conditions, high blood pressure, back or neck issues refrain from full participation in high ropes experiences and physically spotted activities. Expectant mothers (without a specific medical release) are not permitted to fully participate at height on ropes courses or with spotted activities.

Release: I, for myself and for my heirs, personal representatives, and assigns, and each of them, forever release and fully discharge Joy Outdoor Education Center, LLC and Joy Outdoor Education Center Foundation, Inc., and each of their members, managers, directors, employees, volunteers, agents, officers, predecessors, affiliates (including the Warren County Astronomical Society with respect to our Observatory), representatives, successors, and assigns, from any and all actions, causes of action, claims, costs, damages, demands, fees, and/or liability of any kind, nature, or descriptions whatsoever, whether known or unknown, arising out of or in any way related, whether directly or indirectly, to participation in any Camp Joy program, including, but not limited to any physical injury, psychological injury, or loss of life or personal property that may occur as a result of participating in this program.

Signature of parent/legal guardian _____Date _____

If child is in foster care, signature of Case Worker : _____ Date _____

I DECLINE to give my consent for my child to be photographed for general camp and/or agency printed/ internet publicity
Signature of parent/legal guardian _____ Date _____

2017 CAMP JOY HEALTH FORM

Camp Joy, PO Box 157, Clarksville, OH 45113 937-289-2031

APPLICATION WILL NOT BE PROCESSED WITHOUT THIS INFORMATION.

This form should be completed by the camper's parent or guardian.

Camper Name: _____

PHYSICIAN & INSURANCE INFORMATION

Family Physician's Name _____ Phone _____Family Dentist's Name _____ Phone _____

Medical/Hospital Plan: _____ Policyholders First & Last Name _____

Health Insurance Company/Carrier _____ Policy or Group # _____

MEDICAL CONDITIONS:

- ❑ None
- ❑ Ear Infections
- ❑ Diabetes
- ❑ Infectious Hepatitis
- ❑ **Asthma**
  - Triggers _____
  - Frequency of rescue inhaler use _____
- ❑ **Seizures/convulsions/Epilepsy**
  - Seizure type _____
  - Treatment (medication, dosage, when to give medication, etc)

    _____

    _____
- ❑ Pregnancy
- ❑ Heart Disease
- ❑ Fainting
- ❑ Headaches
- ❑ High Blood Pressure

MEDICATIONS Yes _____ or No _____

If yes, please specify below

Prescribed and Over the Counter Medicine to take at Camp

Name/Reason

1. _____/_____
2. _____/_____
3. _____/_____
4. _____/_____

IMMUNIZATIONS AND HISTORY:

Are the child's immunizations up to date?

Please Circle One: Yes No

Please give date of most recent tetanus shot or booster: Date: _____

ALLERGIES Yes____ or No_____ If yes, please elaborate below

Please list all medication, food and other allergies (including stings, poison ivy, seasonal, hay fever, etc.) and how to treat them.

***Please provide an Epi Pen if your child needs one. *Please see camp nurse if you have further concerns

Type (nuts, stings, medication, etc)	Severity (mild, moderate, severe)	Treatment (Benadryl, Epi pen)

Describe and give dates of any hospitalizations, serious injuries or recurring illnesses: _____

Does the camper have any physical restrictions? Yes or No

If yes, please explain_____

Does your camper have any dietary restrictions? Yes or No

If yes, please explain: _____

Does the camper have any current physical, mental or psychological conditions requiring medication, treatment or, restrictions at camp: Yes _____ or No _____

if yes, please explain _____

_____

In case of pain, or sickness give this participant:

_____Nothing _____Acetaminophen (Tylenol) _____ Ibuprofen (Advil) _____Cough Drops _____Imodium AD _____Benadryl

_____Benadryl Cream ____ Cortisone Cream _____Other List: _____

PARENTAL ACKNOWLEDGMENT AND CONSENT

The health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted. **Authorization for treatment:** I hereby give permission to the medical personnel selected by Camp Joy to provide routine health care, administer prescribed medications, and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes; I give permission to Camp Joy to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Camp Joy to secure and administer treatment, including hospitalization, for the person named above. I give permission to the Camp Joy medical staff to assist my child with over-the-counter medication if needed.

Signature of Parent/Legal Guardian _____ Date_____

CREDIT CARD PAYMENT FORM

(Revised 08/2011)

Card Holder: Name on Card: _____

Zip Code associated with the Card: _____

Phone #: _____

Contact if different from above information:

Email: _____

- Charge is to cover: _____

  _____

  _____

Program: _____

Program Date: _____

Charge Amount $ _____

____MasterCard ____American Express ____Visa ___ Discover

Card Number: _____ Exp. Date_____

CVV #_____ (MC & Visa 3 digit# on back of card, AX 4 digit # on front of card)

2017 CAMP JOY / OHIO SUMMER FOOD SERVICE PROGRAM APPLICATION

FOR OFFICE USE ONLY:
$ _____ Monthly Income
_____ Approved
_____ Denied
Signature of Authorized Official

_____

Date _____/_____/_____

Joy serves nutritious meals as part of the federally funded Summer Food Service Program for Children.
Thank you for your time to help JOY in this reimbursement program!

COMPLETE & SIGN SECTION 1, 2 or 3

I certify that all of the below information is true and correct. I understand that this information is being given for receipt of federal funds; that program officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws

Camper's Name_____

1 FOR CHILDREN RECEIVING FOOD STAMPS OR OWF

___Yes, I received Food Stamp or OWF benefits for the child listed above this month and request meal benefits.

__ __ __ __ __ __ __ __ __ __

Food Stamp Case Number (10 digit #)
Your 10 digit case number can be found on your certification letter from SNAP or OWF.

OR

_____

OWF/TANF Identification #

_____ _____
Signature of Adult Household Member Date

OR

2 FOR FOSTER CARE CHILDREN

____ Yes, the camper is under the legal responsibility of a human service agency and is living in our household.

Personal Use Income of Foster Child:
$_____
"O" if the child has no personal use income.

_____ _____
Signature of Adult Household Member Date

Income Eligibility Information for Section 3:

REDUCED INCOME ELIGIBILITY GUIDELINES – 185% Guidelines
to be effective from July 1, 2016 through June 30, 2017
Households with incomes less than or equal to the reduced price values below are eligible for free or reduced-price meal benefits.

HOUSEHOLD SIZE	YEAR	MONTH	TWICE PER MONTH	EVERY TWO WEEKS	WEEK
1	21978	1,832	916	846	423
2	29,637	2,470	1,235	1,140	570
3	37,296	3,108	1,554	1,435	718
4	44,955	3,747	1,874	1,730	865
5	52,614	4,385	2,193	2,024	1,012
6	60,273	5,023	2,512	2,319	1,160
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
For each additional family member, add	7,696	642	321	296	148

OR

3 FOR CHILDREN NOT CURRENTLY RECEIVING FOOD STAMPS OR OWF

LIST ALL HOUSEHOLD MEMBERS' NAMES	**Gross** Monthly Earnings	**Monthly** Welfare/ Child Support / Alimony / OWF	**Monthly** Pensions/ Retirement / Social Security	**Monthly** Other income

_____ __ __ __ __ _____
Signature of Adult Household Member Last 4 Digits of Social Security # Date

Section 9(d) of the National School Lunch Act requires that the primary wage earner, or adult household member signing the application, include their social security number but if you refuse, your child may not receive free meals. The social security number may be used to identify you for verifying the information reported on this application. Verification may include audits; investigations; contacting the state employment security office, Food Stamp or welfare office, and employers; and checking the written information provided by the household to confirm the information received. If incorrect information is discovered, a loss of benefits or legal action may occur. These facts must be told to the household member whose Social Security number in reported on this form..

NON-DISCRIMINATION: No child will be discriminated against because of race, color, national origin, sex, age or disability. This facility is operated in accordance with USDA policy, which does not permit discrimination because of race, color, national origin, sex, age or disability. Any person who believes that he or she has been discriminated against in any USDA related activity should write immediately to the Secretary of Agriculture, Washington D.C., 20250.