

**Please fill out the following forms and bring it to  
to Pawtucket Family YMCA's member services desk**

**Pawtucket Family YMCA**  
Attn: Summer Camp Registration  
20 Summer Street  
Pawtucket, RI  
(401) 727-7900

# 2011 YMCA SUMMER CAMP REGISTRATION

We must have 2 weeks written notice prior to a child cancelling camp or you will be charged the full amount.

Please print all information clearly (blue or black pen only)

**Camper's Name:** \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Grade (Fall 2011): \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Ethnicity (optional):

Caucasian \_\_\_\_\_ Latino \_\_\_\_\_ Asian \_\_\_\_\_ African American \_\_\_\_\_ Native American \_\_\_\_\_ Other \_\_\_\_\_

**1st Parent/Guardian:** \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Place of Work: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**2nd Parent/Guardian:** \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Place of Work: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Child resides with: 1st Parent \_\_\_\_\_ 2nd Parent \_\_\_\_\_ Guardian \_\_\_\_\_ Both \_\_\_\_\_ Other \_\_\_\_\_

## MEDICAL INFORMATION:

Each camper's medical background is **required** as part of the camp's registration process. The camp director must be advised **in writing** of any conditions that would limit the campers ability to participate in any programs.

Current Health Status (allergies, diseases, dietary restrictions): \_\_\_\_\_

Specific activities to be restricted from for health reasons: \_\_\_\_\_

List any conditions requiring medication, treatment or special restrictions or considerations: \_\_\_\_\_

List of current and past medical treatments: \_\_\_\_\_

Record of immunizations including date of last tetanus shot: \_\_\_\_\_

If the camper is on any prescribed or over the counter medications - Please List \_\_\_\_\_

Does the camper need to take the medication at camp? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please request a medical dispensing form

## TRANSPORTATION:

No child **under the age of 6** may ride a bus without being accompanied by a sibling - 10 years or older.

**Please indicate the form of transportation, including pick up & drop off - See Back Page for schedule.**

Morning Bus Stop Number \_\_\_\_\_ Pick Up Location \_\_\_\_\_

Afternoon Bus Stop Number \_\_\_\_\_ Drop Off Location \_\_\_\_\_



# 2011 PARENT AUTHORIZATION FORM

*Please print all information clearly*

Name of Camper: \_\_\_\_\_ Today's Date \_\_\_\_\_

The YMCA of Pawtucket, Inc. does not discriminate on the basis of race, color, sex, handicap, religion or national origin. The YMCA of Pawtucket, Inc. reserves the right at its sole discretion to refuse an application or dismiss a child from camp. No refund will be made of fees if the child has attended any portion of the camping period.

I understand and accept these guidelines \_\_\_\_\_  
(Parent/Guardian's Signature)

I give the YMCA of Pawtucket, Inc. permission to photograph and/or videotape my child for public relations and/or marketing purposes. Photos will remain archived at the YMCA of Pawtucket, Inc. and can be used for promotional purposes without notification.

\_\_\_\_\_  
(Parent/Guardian's Signature)

I give permission for the YMCA of Pawtucket, Inc. to transport my child off camp property for the purpose of field trips and/or medical care. I understand that a schedule of events will be available to me and that all events are subject to change due to weather and/or scheduling conflicts without notice.

\_\_\_\_\_  
(Parent/Guardian's Signature)

I authorize the camp management to act as the agent of the parents in any emergency situation or to administer basic first aid for the health and welfare of the camper involved. I am responsible for the expenses involved if the services of a physician or hospital are required. Please request a waiver for persons requesting exemption from medical treatment.

\_\_\_\_\_  
(Parent/Guardian's Signature)

Name and phone number(s) of person(s) **other than parents** allowed to pick up your child.

1. \_\_\_\_\_ Home Phone: \_\_\_\_\_

Relationship to camper: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

2. \_\_\_\_\_ Home Phone: \_\_\_\_\_

Relationship to camper: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

3. \_\_\_\_\_ Home Phone: \_\_\_\_\_

Relationship to camper: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Any special instructions, such as custody or restraining orders must be attached to this application and discussed personally with the camp director. All information will be kept confidential.**

# 2011 SUMMER CAMP PAYMENT AGREEMENT

\_\_\_\_\_  
PRINT NAME OF CHILD(REN)

\_\_\_\_\_  
DATE

***EASY PAYMENT PLAN I - Automatic Bank Draft***

(weekly draft from checking or savings account)

\_\_\_\_\_  
PRINT NAME ON THE ACCOUNT

\_\_\_\_\_  
ROUTING & ACCOUNT # (ATTACH VOIDED CHECK)

CHECKING  
 SAVINGS

\_\_\_\_\_  
NAME OF BANK

\_\_\_\_\_  
AUTHORIZED SIGNATURE

\_\_\_\_\_  
DATE

***EXPRESS PAYMENT PLAN II - Credit Card***

(weekly charge to credit card - Visa, Mastercard, etc.)

\_\_\_\_\_  
CREDIT CARD TYPE

\_\_\_\_\_  
YOUR NAME AS IT APPEARS ON CARD

\_\_\_\_\_  
CREDIT CARD #

\_\_\_\_\_  
EXP. DATE

\_\_\_\_\_  
AUTHORIZED SIGNATURE

\_\_\_\_\_  
DATE

***PAYMENT PLAN III - Cash/Check*** (weekly payment)

- I do not wish to participate in either Express Payment Plan at this time.
- I understand that the weekly fee is due the **FRIDAY BEFORE** camp.
- I understand that the full week is due whether or not my child attends **(unless I give the YMCA written notice of cancellation 2 weeks prior)**
- I understand a deposit of \$20.00 for each week is required at the time of registration if I choose not to participate in either Express Payment Plan.
- This deposit will go toward the balance for each week. Deposits are non-refundable and non-transferable after June 1st.
- I understand trip fees are due at time of registration and are non-refundable.

\_\_\_\_\_  
AUTHORIZED SIGNATURE

\_\_\_\_\_  
DATE

# 2011 MEAL BENEFIT FORM

Discharge Date: \_\_\_\_\_

Part 1. Children in Day Care (Use a separate application for each foster child)			
Names of all children in care (First, Middle Initial, Last)	√ if Foster Child	Date of Birth	Supplemental Nutrition Assistance Program (SNAP) or RI WORKS case # for any member of the household. If you list a case #, skip to part 4.

Part 2. Total Household Gross Income You must tell us how much and how often						
<b>1. Name</b> (List everyone in household, including foster children)	<b>2. Gross income and how often it was received</b> <i>Examples: \$250/monthly \$400/twice a month \$125 every other week 190/weekly</i>				3. Check if <b>NO</b> income	
	Earnings from work before deductions	Welfare, Alimony, Child Support	Pensions, Retirement, social security	Other		
1.					<input type="checkbox"/>	
2.					<input type="checkbox"/>	
3.					<input type="checkbox"/>	
4.					<input type="checkbox"/>	
5.					<input type="checkbox"/>	
6.					<input type="checkbox"/>	
7.					<input type="checkbox"/>	
8.					<input type="checkbox"/>	
9.					<input type="checkbox"/>	

Part 3. Signature and Social Security Number (Adult must sign)	
<p>An adult household member must sign the application. If Part 2 is completed, the adult signing the form must also list the last four numbers of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this form.)</p> <p><i>I certify (promise) that all information on this application is true and that all income is reported. I understand that the childcare program will get Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, I may be prosecuted.</i></p> <p>Sign here: _____ Date: _____</p> <p>Social Security Number (last 4 numbers only): ____ _ ____ _      <input type="checkbox"/> I do not have a Social Security Number</p>	

Part 4. Children's racial and ethnic identities (optional)
<p><u>Choose one ethnicity:</u>  <input type="checkbox"/> Hispanic or Latino    <input type="checkbox"/> Not Hispanic or Latino</p> <p><u>Choose one or more (regardless of ethnicity):</u>  <input type="checkbox"/> Asian    <input type="checkbox"/> Black or African American    <input type="checkbox"/> American Indian or Alaskan Native    <input type="checkbox"/> Native Hawaiian or Other Pacific Islander    <input type="checkbox"/> White</p>

Don't fill out this part. This is for official use only.
<p style="text-align: center;"><b>Monthly Income Conversion: Weekly X 4.33, Every 2 Weeks X 2.15, Twice A Month X 2</b></p> <p>Total Income: _____ Per: ___ Week, ___ Every 2 weeks, ___ Twice a Month, ___ Month, ___ Year    Household size: _____</p> <p>Categorical Eligibility: _____</p> <p>Eligibility: Free _____ Reduced _____ Denied _____ Reason: _____</p> <p>Temporary: Free _____ Reduced _____ Time Period: _____ (expires after _____ days)</p> <p>Determining Official's Signature: _____ Approval Date: _____</p>

### Instructions for Completing Meal Benefit Form

**Foster children are eligible for free meals regardless of household income. If you wish to apply for meals for a FOSTER CHILD living with you, follow these instructions:**

Part 1: List the child's name and date of birth.

Part 2: Skip this part unless you have other children in your family that you would like to see if they are eligible for free or reduced price meals.

Part 3: Sign the form. A Social Security Number is not necessary if you are only applying for benefits for a foster child.

Part 4: Answer this question if you choose to.

**If your household gets SNAP OR RIWorks, follow these instructions:**

Part 1: List each child's name, date of birth, and SNAP or RIWorks case number.

Part 2: Skip this part.

Part 3: Sign the form. A Social Security Number is not necessary.

Part 4: Answer this question if you choose to.

**ALL OTHER HOUSEHOLDS, follow these instructions (include all foster children in addition to family members):**

**Part 1:** List each child's name and date of birth attending this day care center.

**Part 2:** Follow these instructions to report total household income from last month.

**Column 1- Name:** List the first and last name of **each** person living in your household, related or not (such as grandparents, foster children, other relatives, or friends). You must include yourself. Attach another sheet of paper if you need to.

**Column 2- Gross income and how often it was received:** For each household member, list each type of income received for the month. You must tell us how often the money is received—weekly, every other week, twice a month or monthly. For earnings, be sure to list the **gross income**, not the take home pay. **Gross income is the amount earned before taxes and deductions.** It should be listed on your pay stub, or your boss can tell you. For other income, list the amount each person got for the month from welfare, child support, alimony, pensions, retirement, Social Security, Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household, and ANY OTHER INCOME. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

**Column 3- Check if no income:** If the person does not have any income, check the box.

**Part 3:** An adult household member must sign the form and list the last four numbers of his/her Social Security Number, or mark the box indicated if he or she doesn't have one.

**Part 4:** Answer this question if you choose to. We request this information solely for the purpose of determining compliance with Federal civil rights laws, and your response will not affect consideration of your application. By providing this information, you will assist us in assuring that this program is administered in a nondiscriminatory manner.

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**Privacy Statement Act: This explains how we will use the information you give us.** The National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your children for free or reduced price meals (if the daycare program has a separate charge for meals) or the day care center may not receive maximum federal funds for providing a meal program (if the daycare program provides meals at no charge). The Social Security Number of the adult household member who signs the application is required unless you list the Food Stamp or FIP case number for all the children you are applying for, OR if you are applying for a foster child. You must check the "I do not have a Social Security Number" box if the adult household member signing the application does not have a Social Security Number. We WILL use your information to see if your children are eligible for free or reduced price meals, to run the program, and to enforce the rules of the program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into misuse of program rules.

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**Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.** In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (800) 795-3272 or (202)-720-6382 (TTY). USDA is an equal opportunity provider and employer.

In addition, the RI Department of Education does not discriminate on the basis of sexual orientation or religion. To file a complaint of discrimination with the RI Department of Education, write RI Department of Education, Director, Office of Equity and Access, 255 Westminster Street, Providence, RI 02903 or call 401-222-4600.

**Need low or no cost health insurance for your children? Call RiteCare at 462-5300 (462-3363 TTY)**