

MOUNT KISCO RECREATION DEPARTMENT 2023 CAMP IROQUOIS REGISTRATION FORM

PLEASE PRINT CLEARLY.

CAMP IROQUOIS & EXTENDED DAY PROGRAM INFORMATION: PLEASE CHECK THE APPROPRIATE BOX(S) BELOW.

<input type="checkbox"/> CAMP IROQUOIS DAY CAMP (8:30AM-3:00PM)	<input type="checkbox"/> EXTENDED DAY CAMP (3:00PM-6:00PM)
<input type="checkbox"/> 4 Weeks: Session I (June 26 - July 21)	<input type="checkbox"/> 4 Weeks: Session I (June 26 - July 21)
<input type="checkbox"/> 3 Weeks: Session II (July 24 - August 11)	<input type="checkbox"/> 3 Weeks: Session II (July 24 - August 11)
<input type="checkbox"/> 7 Weeks: Session III (June 26 - August 11)	<input type="checkbox"/> 7 Weeks: Session III (June 26 - August 11)

CAMPER, GUARDIANS, PHYSICIAN, & INSURANCE INFORMATION:

Camper's First Name: _____ Last Name: _____
Grade **ENTERING** in the 2023 - 2024 School Year: _____ Gender: _____ Age: _____ D.O.B.: ____/____/____
Residential Status: Resident Non-Resident T-shirt Size (Please check the box and fill in the Size): Yth. ____ Adt. ____
Mailing Address: _____ Home Phone #: _____
Guardian 1 Full Name: _____ Relationship: _____
Email Address: _____ Cell Phone #: _____ Work Phone #: _____
Guardian 2 Full Name: _____ Relationship: _____
Email Address: _____ Cell Phone #: _____ Work Phone #: _____
Physician's Full Name: _____ Phone #: _____
Insurance Company: _____ Policy #: _____

IMMUNIZATION RECORDS INFORMATION:

PLEASE CHECK THE BOX & INITIAL BELOW.

As required by the NYSDOH & WCDOH every year, all camper registrations MUST include a copy of your child's immunization records. The immunization records MUST come from the child's Physician/Health Care Provider, on their letterhead, and signed/stamped.

IMMUNIZATION RECORDS ATTACHED: _____ INITIALS: _____

EMERGENCY CONTACTS INFORMATION:

PLEASE PROVIDE AN ADDITIONAL ADULT(S) THAT WE CAN CONTACT, IF THE GUARDIAN(S) **CAN NOT** BE REACHED.

1) Full Name: _____	Relationship: _____	Phone: _____
2) Full Name: _____	Relationship: _____	Phone: _____
3) Full Name: _____	Relationship: _____	Phone: _____

FRIEND REQUEST INFORMATION:

FRIEND REQUESTS ARE NOT GUARANTEED, BUT WE TRY TO ACCOMMODATE ALL OR AT LEAST ONE REQUEST.

Friend Request (Please submit three (3) Names): 1) _____ 2) _____ 3) _____

DISMISSAL INFORMATION:

PLEASE CHECK THE APPROPRIATE BOX(S) & INITIAL BELOW.

At the end of the camp day, my child will:

Be Picked Up By: 1) _____ 2) _____ 3) _____
 Go Home With: 1) _____ 2) _____ 3) _____
 Attend the Extended Day Camp. Leave on their own. *** No Camper will be dismissed to the Memorial Pool.**

PLEASE NOTE: Everyone MUST show; a Photo ID to the Group's Head Counselor or Designated Staff member. If you would like anyone NOT listed above to pick up your child from camp, you MUST send in a note or call the Camp Office at: (914) 666 - 9823.

DISMISSAL INFORMATION: _____ INITIALS: _____

SWIMMING ASSESSMENT INFORMATION:

PLEASE CHECK THE BOX & INITIAL BELOW.

I authorize my child to participate in Camp Iroquois's "Swimming Assessment Test" given by our Water Safety Instructor (WSI). The swimming assessment test determines each camper's swimming ability for all camp aquatic activities (Ie. buddy lists, swimming lessons, free swimming, color wars, etc.). I understand that my child will be grouped according to their swimming ability at the time of the swimming assessment test. All campers MUST have their swim abilities assessed within the first three (3) days of camp. All campers will have the opportunity to be reevaluated, at a later date, to determine if their swimming ability status has improved. **PLEASE NOTE:** This is required by the NYSDOH & WCDOH for each camper to participate in our aquatic activities.

CAMP IROQUOIS SWIMMING ASSESSMENT TEST: _____ INITIALS: _____

PLEASE ATTACH ANY ADDITIONAL INFORMATION TO THE BACK OF THIS FORM.

MEDICAL RELEASE INFORMATION:

PLEASE CHECK THE BOX & INITIAL BELOW.

I hereby certify that my child is in good physical and mental health. I give my child permission to take part in all camp activities and/or trips unless otherwise indicated in writing. If I cannot be reached in the event of an injury, I give my permission to Camp Staff to take my child to a nearby hospital/medical facility for treatment, X-rays, evaluation, etc. for injury. I also understand that the Village/Town of Mount Kisco does not maintain medical insurance for program participants and that persons participating do so at their own risk.

MEDICAL RELEASE:

INITIALS: _____

PRESCRIBED MEDICATION, OVER-THE-COUNTER (OTC), EPI-PEN, INSECT REPELLENT, WATERPROOF SUNSCREEN, ASTHMA, ALLERGIES, SPECIAL ACCOMMODATIONS, & COVID, INFORMATION:

PLEASE CHECK THE APPROPRIATE BOX(S) & INITIAL EACH ITEM SELECTED BELOW.

If you answered **YES**, to any of the above questions, you **MUST** fill out and submit a separate additional Medical Form two (2) weeks before the start of camp. All forms are posted on our website, please choose the form required for your child's needs listed below. Please provide any additional information on a separate sheet of paper and attach it to the back of the form(s), if needed.

PRESCRIBED MEDICATION(S): Is your child on/under any prescribed medication? Yes No **INITIALS:** _____

OVER-THE-COUNTER (OTC) MEDICATION: Is your child taking any OTC medications? Yes No **INITIALS:** _____

EPI-PEN: Does your child need to use an EPI-PEN? Yes No **INITIALS:** _____

INSECT REPELLENT: Does your child need to use Insect Repellent? Yes No **INITIALS:** _____

WATERPROOF SUNSCREEN: Does your child need to use Sunscreen? Yes No **INITIALS:** _____

ASTHMA: Does your child have Asthma? Yes No **INITIALS:** _____

ALLERGIES: Does your child have any Allergies? Yes No **INITIALS:** _____

SPECIAL ACCOMMODATIONS: Does your child need Special Accommodations? Yes No **INITIALS:** _____

❖ Please be Specific when listing Allergies and your child's Allergic Reaction(s).

❖ If your child has Asthma, they **MUST** bring their Inhaler to camp Every Day, No Exceptions!

COVID-19: Has your child received a COVID-19 Vaccine Shot? Yes No **INITIALS:** _____

If you answered **YES**, please check the appropriate box. Partially (1 Dose) Fully (2 Doses) Fully (2 Doses) +Booster

PLEASE NOTE: This has no effect on camp acceptance, and is only for NYSDOH & WCDOH tracking purposes.

BEHAVIORAL & ZERO TOLERANCE POLICY INFORMATION:

PLEASE REVIEW WITH YOUR CHILD, CHECK THE BOX & INITIAL BELOW.

Any Camper(s) that is/are involved in any of the following incidents or situations listed below at Camp Iroquois and/or the Extended Day camp will automatically be suspended and/or terminated from the program. ALL offenses/incidents will be documented. Please Note: any incident depending on its severity may be grounds for suspension and/or immediate termination from the program with NO refund.

- Bullying, fighting, or any other violent action. ALL campers involved will be disciplined.
- Hateful language, using profanity, or harassment of any kind.
- Theft or vandalism of any kind.
- Running away from staff members, and/or the group.
- Use of tobacco, vapes, illegal substances, and/or alcohol products.

It is certainly **NOT** our desire to hold out, suspend, or terminate campers from our program, and most behavioral problems will be corrected long before the third offense/incident occurs. Our policy is designed to resolve behavioral issues promptly and with the camper's parents/guardians' knowledge of the actions taken. Poor behavior sometimes affects the entire group of campers and this will **NOT** be tolerated. The goal of this policy is to prevent any issues that may arise and to keep everyone involved informed.

BEHAVIORAL & ZERO TOLERANCE POLICY:

INITIALS: _____

NON-DISCRIMINATION STATEMENT BASED ON DISABILITY INFORMATION:

PLEASE CHECK THE BOX & INITIAL BELOW.

The Village/Town of Mount Kisco will **NOT** discriminate against any individual based on disability concerning the full and equal enjoyment of the goods and services program. The Village/Town of Mount Kisco will make reasonable modifications to its policies, practices, and/or procedures when necessary to afford its goods and services to individuals with disabilities, allergies, or that may require the administration of medications unless the Village/Town of Mount Kisco can demonstrate that making the modifications would fundamentally alter the nature of the services/programs, and/or not otherwise be feasible.

The Village/Town of Mount Kisco will take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated, or otherwise treated differently than other individuals because of the absence of auxiliary aids and services unless the Village/Town of Mount Kisco can demonstrate that taking such steps would fundamentally alter the nature of the good, service, facility, privilege, advantage, or accommodation being offered.

Guardian, please contact Kyle Thornton, Superintendent of Recreation at Kthornton@mountkisco.ny.gov or at (914) 666 - 3059, if your child has a disability that may require special or additional accommodation.

NON-DISCRIMINATION STATEMENT BASED ON DISABILITY:

INITIALS: _____

SIGNATURE OF GUARDIAN:

Signature of Guardian

Printed Name of Guardian

____ / ____ / ____
Date