

Summer Day Camp 2019



<p>For Office Use Only</p> <p>Date Received: _____</p> <p>Received By: _____</p>	<p><input type="checkbox"/> Application</p> <p><input type="checkbox"/> Copies of parent IDs</p> <p><input type="checkbox"/> Copy of child's birth certificate</p>
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My Child, _____ will be attending Summer Day Camp: (Please select weeks of attendance)

	Week	Dates	Excursion
<input type="checkbox"/>	1	June 24-June 28	Natural History Museum
<input type="checkbox"/>	2	July 1- July 5 (Closed on the 4 th)	Santa Ana Zoo
<input type="checkbox"/>	3	July 8 – July 12	South Coast Botanical Gardens
<input type="checkbox"/>	4	July 15 – July 19	Discovery Cube
<input type="checkbox"/>	5	July 22 – July 26	Adventure City
<input type="checkbox"/>	6	July 29 – August 2	John's Incredible Pizza
<input type="checkbox"/>	7	August 5 - 9	CA Science Center
<input type="checkbox"/>	8 & 9 *	August 12 – 16 & August 19 – 23 *	Musical Theater Production

*** Weeks 8 & 9 must be purchased together. Students will all be participating in a musical theater production. Students will be involved in auditions, choir, dance, acting, and set-design.**

The Salvation Army Torrance

4223 Emerald Street Torrance, CA 90503

Main Office: 310-370-4515

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www.torrancecorps.org/aots



Parental Statement of Enrollment

I wish to enroll my child in the Academy of the Son at The Salvation Army Torrance Corps. In signing this application, I agree that after a place has been secured, my child will participate in all activities while he/she is enrolled unless enrollment is cancelled, or my child is dismissed for breach of policy.

Parent's Acknowledgement of Handbook

I acknowledge receipt of the Parent Handbook and agree to read and abide by the rules, practices, and guidelines for my child while participating in the Academy of the Son Summer Day Camp.

Parent Agreement of Payment

I agree to pay the Day Camp fee of \$150 per week for my child to attend. In signing this application, I agree to the terms of payment below.

Payment options:

1. Payment can be made in full at the time of enrollment.
2. Payment can be made on a weekly basis throughout the summer, in which case a minimum deposit of \$5 per week of attendance must be paid at time of enrollment.
 - Payments are due no later than the Monday of each week of attendance.
 - Payments can be made by cash, check or debit/credit card (AMEX not accepted).
 - Refunds will only be provided to those who cancel with a minimum of 2-weeks notice.

By signing below, I agree to the policies of the Academy of the Son Summer Day Camp as outlined in this enrollment packet and 2019 Parent Handbook.

Child's Name _____

Parent's Name _____

Parent Signature _____

Date _____

Activity Release

I, _____, parent/guardian of _____, give permission for him/her to attend and participate in activities sponsored by The Salvation Army Torrance Corps Academy of the Son.

I agree to the conditions, regulations and policies of The Salvation Army, and accept full financial and legal responsibility. Additionally, I authorize the Administrators of this program to provide reasonable and necessary emergency medical treatment to my child should it become necessary during their participation in this program.

I agree to relieve The Salvation Army, it's directors, officers, employees, volunteers, agents or other representatives from any and all liability in connection with any loss, damage or injury arising from my child's participation in the program, except as such loss, damage or injury arises from The Salvation Army's sole negligence.

I acknowledge that I have carefully read this document, that I know and understand its content, and that I sign this document by my own free will.

Photograph & Transportation Consent

I hereby give my consent and permission to The Salvation Army of Torrance, to photograph my child and to use any and all such photographs for any and all promotional purposes of The Salvation Army.

I hereby give my consent and permission to The Salvation Army to transport my child/ren from any and all facilities necessary or youth programming.

(Child's Name – Please Print)

(Date)

(Parent's Name – Please Print)

(Parent's Signature)

(Parent's Phone Number)

(Emergency Contact Name)

(Emergency Contact Phone Number)

HEALTH AND YOUTH ENROLLMENT INFO



DOING THE MOST GOOD

Please fill this out and bring it in to the Community Center.
If you have questions, call (310) 370-4515

PARTICIPANT INFORMATION

NAME (FIRST, MIDDLE, LAST)

BARCODE

YOUTH ENROLLMENT INFO

SCHOOL

SHIRT SIZE

Water Safe: Water safe children have received lessons on basic survival swimming skills, including how to float and tread water.

My Child is Water Safe My Child is NOT Water Safe

ANY SPECIAL PICKUP INSTRUCTIONS?

EMERGENCY & PICKUP CONTACTS

NAME		RELATIONSHIP	
CELL	HOME	WORK	EXT
EMAIL			
CHECK ALL THAT APPLY	<input type="checkbox"/> EMERGENCY CONTACT	<input type="checkbox"/> GUARDIAN	<input type="checkbox"/> AUTHORIZED FOR PICKUP

NAME		RELATIONSHIP	
CELL	HOME	WORK	EXT
EMAIL			
CHECK ALL THAT APPLY	<input type="checkbox"/> EMERGENCY CONTACT	<input type="checkbox"/> GUARDIAN	<input type="checkbox"/> AUTHORIZED FOR PICKUP

NAME		RELATIONSHIP	
CELL	HOME	WORK	EXT
EMAIL			
CHECK ALL THAT APPLY	<input type="checkbox"/> EMERGENCY CONTACT	<input type="checkbox"/> GUARDIAN	<input type="checkbox"/> AUTHORIZED FOR PICKUP

HEALTH INFORMATION

IMMUNIZATIONS UP TO DATE YES NO EXEMPT TETANUS MM/YY N/A

PHYSICIAN'S NAME PHONE

INSURANCE COMPANY POLICY #

MEDICATIONS (NAME & PURPOSE):

DIETARY RESTRICTIONS:

ACTIVITY RESTRICTIONS:

HEALTH HISTORY:

CHECK ALL THAT APPLY

- Asthma
- Behavioral Challenges
- Carriers Inhaler
- Carries Epi-pen
- Diabetes
- Epilepsy
- Insect Stings Allergy
- Penicillin Allergy
- Special Needs

PLEASE LIST ANYTHING ELSE WE SHOULD KNOW ABOUT YOU:

IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ()
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
BIRTHDATE					
FATHER'S/GUARDIAN'S/FATHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ()					
MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ()	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ()					
PERSON RESPONSIBLE FOR CHILD	LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ()	BUSINESS TELEPHONE ()

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ()

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

- CALL EMERGENCY HOSPITAL OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE
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TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT
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CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER'S DOMESTIC PARTNER'S NAME	DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?	
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME	DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?	
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?	DATE OF LAST PHYSICAL/MEDICAL EXAMINATION	

DEVELOPMENTAL HISTORY (*For infants and preschool-age children only)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
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DAILY ROUTINES (*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST	WHAT ARE USUAL EATING HOURS? BREAKFAST _____ LUNCH _____ DINNER _____
	LUNCH	
	DINNER	

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?
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IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

WORD USED FOR "BOWEL MOVEMENT"*	WORD USED FOR URINATION*
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PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE

DATE

PERSONAL RIGHTS

Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

- (a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:
- (1) To be accorded dignity in his/her personal relationships with staff and other persons.
 - (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.
 - (3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.
 - (4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.
 - (5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.
 - (6) Not to be locked in any room, building, or facility premises by day or night.
 - (7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

ADDRESS

CITY

ZIP CODE

AREA CODE/TELEPHONE NUMBER

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:

PLACE IN CHILD'S FILE

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)

(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: _____

Licensing Office Address: _____

Licensing Office Telephone #: _____

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender" database, go to www.meganslaw.ca.gov

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS (Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

Name of Child Care Center

Signature (Parent/Authorized Representative)

Date

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.

For the Department of Justice "Registered Sex Offender" database go to www.meganslaw.ca.gov

CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

_____ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____. THIS CARE MAY BE GIVEN UNDER
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD

NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE
()

WORK PHONE
()