ORCHARD SUMMER OF DISCOVERY CAMP

Registration Form

PARTICIPANT INFORMATION						
First Name	MI	Last Name		Gender	Birthdate	Grade in 21/22
Home Address		City	Zip	Phone (xxx) xxx-xxxx		

PLEASE SELECT T-SHIRT SIZE. (check one) ____YS ____YM ____YL ____YXL ____AS ____AM ____AL ____AXL

PLEASE ASSESS YOUR CHILD'S SWIM ABILITIES. (check one) _____non-swimmer _____weak swimmer _____strong swimmer

ADULT PAYEE INFORMATION				
First Name	MI	Last Name	Home Phone (xxx) xxx-xxxx	
Email Address		Birthdate	Cell Phone (xxx) xxx-xxxx	

EMERGENCY CONTACT INFORMATION			
Parent/Guardian Name:		Parent/Guardian Name:	
Cell Phone:		Cell Phone:	
Home Address		Home Address	
City	Zip	City	Zip

EMERGENCY CONTACT (other than parents):		
Name:	Phone:	Relationship:

PICK-UP AUTHORIZATIONS

I authorize only the following person(s) to pick up my child (other than parents and emergency contact).

Name: _____ **Phone Number:** _____ **Relationship:** _____

Name: _____ **Phone Number:** _____ **Relationship:** _____

Name: _____ **Phone Number:** _____ **Relationship:** _____

SPECIAL HEALTH CONSIDERATIONS:

Allergies, physical limitations, etc.:

_____

Current Medications:

_____

Medications cannot be administered in camp without a completed Medication Release Form on file from doctor.

Scholarships possible through the Community Services Block Grant (CSBG) and the Kansas Housing Resources Corporation (KHRC)

******Late Fees: After 6:00pm Guardians will be charged $1.00 per minute per child. After 6:30pm Wichita Police will be notified***

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PAYMENT AGREEMENT

Payment Schedule	1st Child	2nd Child	3rd Child+ (per child)
Full Week Fee	$115	$105	$95
May 31 – June 3	$92	$82	$72
June 21 –24	$92	$82	$72
July 6 – 8	$69	$59	$49

- ☐ I understand that as an SOD Program Registrant, a $20 deposit per week per child is due to at the time of registration to reserve a spot for each week I want to enroll my child in. Deposits are non-refundable and non-transferable. *(Deposits are included in the cost of the weekly fee – not in addition to.)
- ☐ The weekly fee is **due the Friday prior to the week attending camp**.
- ☐ Weekly fees can be paid in a lump sum when registering, monthly, bi-weekly, or weekly.
- ☐ Failure to pay weekly fees in a timely manner will result in termination of services until payments due are paid in full.
- ☐ If the child fails to attend two consecutive weeks without notifying the center, they will be withdrawn from camp and deposits will be forfeited.

Signature of Parent/Guardian Date

Signature of Center Director Date

CCL 010
Rev. 5/2020

Kansas Department of Health and Environment
Bureau of Family Health
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Program: (785) 296 -1270 Fax: (785) 559-4244
Website: www.kdheks.gov/kidsnet

Kansas
Department of Health and Environment

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license.	License #
Orchard Recreation Center School Aged Center	**0000446-016**

I authorize Orchard Recreation Center Staff (*caregiver/staff*) who is (are) representative(s) of the above-named facility to give consent for any and all necessary emergency medical care for my child or youth _____ (*child's first and last name)* while child or youth is in the facility's custody

Between 05/31/2022 (MM/DD/YYYY) and 07/29/2022 (MM/DD/YYYY).

Is child covered by health insurance? ☐ Yes ☐ No

If yes, complete the following:

Health Insurance Policy Name _____ Policy Number _____

Medical Assistance Program _____ Card Number _____

Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation: _____ (MM/DD/YYYY)

List any known allergies or other information about the medical conditions of this child or youth pertinent in case of emergency:

_____

_____

_____

Signature of Parent or Guardian	Date Signed

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	Date Signed

Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

State of Kansas
County of _____

Signed or attested before me on _____ (MM/DD/YYYY) by _____ (Name of Person).

(Seal, if any.)

_____
Signature of notarial officer

_____
Title (and Rank)

My appointment expires: _____

The Medical Record/Assessment Form (Or Health Status History form for School Age Programs) and the authorization for Emergency Medical Care must be taken to the emergency room. Both forms must also be in a vehicle when the child or youth is transported by the facility.