AMIGOS CULTURAL CAMP
Amigos / Cambridgeport Community School
15 UPTON STREET - Cambridge, MA 02139

2017 SUMMER REGISTRATION FORM

Child's Name First: _____ Last: _____

Current School _____ Current Grade _____ Male _____ Female _____

Home Address _____ Zip Code _____ Date of Birth _____

Childs Ethnicity (Please Circle) Black White Latino/Hispanic Haitian Asian Other

Does child have any allergies or health concerns? _____

Does child have an IEP (Individual Education Plan) Yes_____ No _____

T- Shirt Size: XS _____ SM _____ MED_____ LG _____ XLG_____

Parent / Guardian 1 Name _____ Email _____

Home Phone _____ Cell Phone _____

Address _____ City _____ Zip _____

Place of Employment _____ Work Phone _____

Parent / Guardian 2 Name _____ Email _____

Home Phone _____ Cell Phone _____

Address _____ City _____ Zip _____

Place of Employment _____ Work Phone _____

I would like to register for the following sessions:

Session 1: June 26 – June 30	8:00 – 3:30 **($200)** _____	8:00 – 5:30 **($240)** _____	**(One week session)**
Session 2: July 3 – July 14	8:00 – 3:30 **($400)** _____	8:00 – 5:30 **($480)** _____	**(No Camp July 4)**
Session 3: July 17 – July 28	8:00 – 3:30 **($400)** _____	8:00 – 5:30 **($480)** _____	
Session 4: July 31 – August 11	8:00 – 3:30 **($400)** _____	8:00 – 5:30 **($480)** _____	

OFFICE USE ONLY

Session 1 Amount Owed $_____ **Session 3** Amount Owed $_____

Session 2 Amount Owed $_____ **Session 4** Amount Owed $_____

Registration Fee: **$25**

Total Tuition: _____ Deposit Paid: ($50 per session) _____

Scholarship _____ CCCB Voucher _____

Balance Due: $ _____

City of Cambridge
Department of Human Service Programs
Information Release Form – Fall 2017

Youth Centers
- o Area IV Pre-teen
- o Area IV MSP
- o Frisoli Pre-teen
- o Frisoli MSP
- o Gately Pre-teen
- o Gately MSP
- o Russell Pre-teen
- o Russell MSP

(MSP=Middle School Partnership)

Community Schools (CS)
- o Amigos/CPort CS
- o Elm Street CS
- o Fitzgerald CS
- o Fletcher Maynard CS
- o Haggerty CS
- o Harrington CS
- o Kennedy CS
- o King CS
- o Linnaean CS
- o Morse CS
- o Tobin CS

Afterschool Childcare
- o Fletcher Maynard K-3
- o King K-2
- o King 2-5
- o Morse K-2
- o Morse 3-5
- o Peabody K-2
- o Peabody 2-5
- o **King Open Extended Day (KOED)**

Preschool Childcare
- o East Cambridge
- o Haggerty
- o King Open
- o M. L. King
- o Morse
- o Peabody

Recreation
- o Camp Rainbow
- o The Cambridge Prgm
- o War Memorial Prgms

I hereby authorize the Department of Human Services (DHSP) to observe my child in his/her school day classroom or program and to discuss my child's educational, physical, medical, psychological and/or other needs with his/her teachers, specialists, therapists, medical providers and other caregivers for the purpose of evaluating his/her participation in DHSP's out of school time (OST) and preschool programs.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ **Date:** _____

PERMISSION TO OBTAIN STUDENT RECORDS

(IEP, 504 Plan, behavior plans)

I hereby authorize my child's school/program to release my child's records including his/her Individualized Education Program (IEP), Behavioral Intervention Plan and/or Section 504 Plan. DHSP will not disclose the content of any such records to any other party without my written consent, except as DHSP may be required by law to do so. All records will be used for the purpose of evaluating my child's participation in DHSP's out of school time (OST) programs.

Parent/Guardian Signature: _____ Date: _____

I decline authorization: _____ Date: _____

Revised 1/2012

City of Cambridge · 51 Inman Street · Cambridge, Massachusetts 02139-1102
Voice: 617-349-6200 · TTY/TDD: 617-492-0235 · Fax: 617-349-6248

City of Cambridge - Department of Human Service Programs
Camp Big Adventure at Morse School
51 Inman Street
Cambridge, MA 02139

Health Form

This form must be completed and signed by a physician and returned before the first day of camp. Information is confidential.

Name of child: _____ Date of Birth: _____

Parent/Guardian 1: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Parent/Guardian 2: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Health care coverage:
Harvard Vanguard _____ ID number: _____

Blue Cross Blue Shield _____ ID number: _____

Medicaid _____ ID number: _____

Other plan (name) _____ ID number: _____

Does your child have any allergies, i.e. hay fever, insect bites, food reactions? Yes ___ No ___ If yes, please describe _____

_____

Does your child have an Epi-Pen for anaphylactic shock? Yes ___ No ___

Does your child have any special dietary restrictions? If yes, please describe

_____

Is your child presently being seen by a physician, staff at a guidance facility or any other health care professional? If yes, by whom and for what reason?

_____

Does your child have any unusual fears or special needs we should be aware of?

_____

Authorization to Administer Medication to a Camper

(To be completed by parent or guardian for campers with medication during camp hours only)

Name of Camper: _____ Age: _____

Food/Drug Allergies: _____

Diagnosis (at parents' discretion):_____

Parent/Guardian Name: _____

Home Telephone: _____ Work Telephone:_____

Cellular Telephone: _____ Emergency Telephone: _____

Name of Licensed Prescriber: _____Telephone: _____

Name of Medication: _____ Dose given at camp: _____

Route of Administration: _____ Frequency: _____

Date Ordered: _____ Duration of Order: _____

Expiration Date of Medication: _____

Storage Requirements: _____

Specific Directions (e.g. on empty stomach, with water): _____

_____

Specific Precautions: _____

_____

Possible Side Effects/Reactions: _____

_____

Other Medications: _____

Location where medication administration will occur:_____

Parents Signature: _____ **Date:** _____

Department of Human Service Programs – Community School Division

Camper Release Form

CHILD'S NAME: _____

PARENT/GUARDIAN NAME: _____

1. I hereby give my child permission to participate in all camp sponsored activities & trips, which may include by school bus, walking, or public transportation.

_____

(Parent / Guardian Initial)

2. I hereby give permission for authorized staff to take my child to the nearest hospital* for emergency treatment. If injury occurs within Cambridge child will be transported to Cambridge City Hospital or Mt. Auburn Hospital. I authorize hospital personal to proceed with emergency treatment for my child if a parent or emergency contact cannot be reached.

_____

(Parent / Guardian Initial)

3. I give permission to the City of Cambridge / Community Schools to use photographic and video images of my child and family for publicity purposes. I acknowledge that publicity could include the use of images in any slide show, website, social media or articles submitted for publication or distribution

_____

(Parent / Guardian Initial)

4. I am not aware of any allergies to sunscreens and I give permission for staff to help child apply if needed.

_____

(Parent / Guardian Initial)

5. If someone other than myself or these individuals is to pick up my child, I will inform director in writing in advance. I understand that staff will ask anyone not on this list to show proper identification before child is released.

NAME _____ PHONE _____

ADDRESS _____ RELATIONSHIP _____

NAME _____ PHONE _____

ADDRESS _____ RELATIONSHIP _____

_____

(PARENT/GUARDIAN SIGNATURE) (DATE)

Immunization Record

(To be completed by physician)

***Please Note**: Camps are not staffed with licensed nurses.

Please indicate dates for the following immunizations for:

Child Name: _____ Date of birth: _____

DTaP/DTP/DT/Td #1_____ #2_____ #3_____ #4_____ #5_____

Td/Tdap Boosters #1_____

Polio IPV/OPV #1_____ #2_____ #3_____ #4_____

Hepatitis B #1_____ #2_____#3_____

MMR #1_____ #2_____

Varicella # 1_____

Other: #1_____

Describe any physical conditions or impairments requiring restrictions in camp activities and indicate specific treatments if needed.

_____

_____

Please provide the name of any medication that is **required** to be taken during camp time.

_____

_____

I hereby certify that _____ **(name of child)** has been examined on _____ **(date),** and that he/she is in good physical condition and is capable of participating in all camp activities.

Medical Facility Name: _____

Address: _____ Phone #: _____

_____ _____

Physician's Signature **Physicians' Name (Printed)**

I hereby give permission for authorized staff to take my child to the nearest hospital for emergency treatment.

_____ _____

Parent/Guardian's Signature **Date**