CAMP BIG ADVENTURE
Morse Community School
40 Granite Street – Cambridge, MA 02139

2018 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 _______

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: July 2 – July 13	8:00 – 3:30 **($450)** ______	8:00 – 5:30 **($530)** ______	(No Camp July 4)
Session 2: July 16 – July 27	8:00 – 3:30 **($450)** ______	8:00 – 5:30 **($530)** ______	
Session 3: July 30 – Aug 10	8:00 – 3:30 **($450)** ______	8:00 – 5:30 **($530)** ______	
Session 4: Aug 13 – Aug 17	8:00 – 3:30 **($225)** ______	8:00 – 5:30 **($265)** ______	(One week session)

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 – Summer 2018

For Staff Use Only:

________________________________ **(PRINT Child's Name)**

____________________________________ **(Name of School)**

Please circle one: NEW STUDENT RETURNING STUDENT

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: _______________

Decline authorization: ____________________________ 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: _______________

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, 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

PRINT CHILD'S NAME: ____

PRINT 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:

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**