



770 Howes Lane
 Columbia, MD 21044
 410-740-2424
 GanIsrael@comcast.net

Gan Israel Day Camp Registration Form

To register, please fill out this registration form and return it to the camp office with a \$50, non-refundable, deposit, per session, for each child. The balance must be paid in full one week prior to the session your child begins to attend camp.

For entrance to Camp in Year _____ Male Female

Child's Last Name _____ First Name _____

Hebrew Name _____ Date of Birth _____

Address _____

City/State /Zip _____

Phone # _____ Parent's Email Address _____

School _____ Grade in September _____

Hebrew School _____ Grade Completed _____

Previous Camp _____ Years attended _____

Mother's Name _____ Hebrew Name _____

Father's Name _____ Hebrew Name _____

Mother's Work _____ Phone # _____

Father's Work _____ Phone # _____

Child's Interests _____

Program (circle one): Tiny Tots (ages 2-4) Older Division (ages 5 and up)

Which session(s) will the child attend: Session 1 Session 2 Session 3 Session 4

Which days will the child attend Camp Gan Israel? Monday Tuesday Wednesday Thursday Friday

Will the child attend: Full-time Part-time Will the child need: Before Care After Care

Will you require a Dependent Care Receipt for your taxes? Yes No

Medical Release Form

I hereby give consent to the administration of Camp Gan Israel to take whatever medical measures they deem necessary for my child in the event of a medical emergency.

Parent's/Guardian's Signature _____ Date _____



Gan Israel Day Camp Medical Form

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Child(ren) Name(s): 1. _____ 2. _____
3. _____ 4. _____

For children in First Grade or older who attend an accredited Maryland school, please verify the location of Medical forms and immunization records:

Location of Health and Immunization Forms: (list each child's name and school where the records are located)

List the County where school(s) is/are located:

For all other children, parents must submit a completed Health Inventory and Immunization Form for Camp Gan Israel to keep on file.

Please be aware that my child has:

Allergies to: (please fill in – PRINT)

Foods: _____

Medications: _____

Special needs: _____

Social/Emotional/Behavioral issues: _____

Medications child takes _____

(Please include administration form from your pediatrician's office and see parent's handbook)

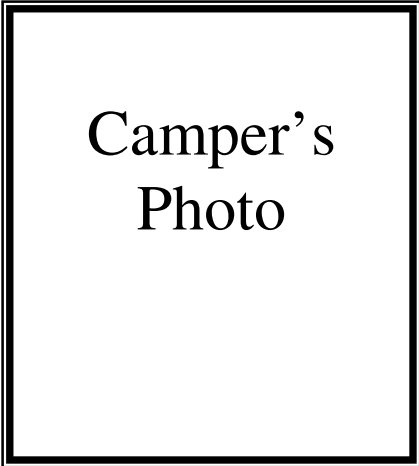
Date of last Tetanus _____

Parent's Signature _____ Date _____



Gan Israel Day Camp Allergy Protocol

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Name of Camper: _____

Allergies: _____

Nature of Reaction:

Hayfever: _____ Anaphylaxis: _____ Other (specify): _____

These allergies occur:

____ On Contact ____ When Ingested ____ When Inhaled ____ Other (Specify) _____

Symptoms (please indicate the symptoms to watch for):

Current Medical Treatment:

None: _____ Non-prescription medication: _____

Prescription medication (specify): _____

Management Ability:

Camper Can recognize and treat reaction on own: _____

Camper needs assistance by adult or medical person: _____

Specify: _____

Please specify a Course of Action to be taken by Camp Gan Israel in case of an allergic reaction:

Parental Authorizations:

I authorize the posting of my child's picture in the camp for the purposes of this protocol. I further authorize the staff of Camp Gan Israel to administer to my child the following medication(s)

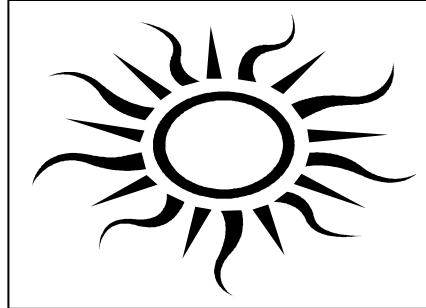
_____.

Parent's/Guardian's Signature _____ **Date** _____



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Gan Israel Day Camp Sunscreen Permission



Gan Israel Day Camp requests that your child arrives to camp with sunscreen applied to all exposed areas of his/her body.

However, re-application of sunscreen may be necessary during the camp day.

I hereby grant permission to Gan Israel Day Camp Counselors and Staff to apply sunscreen on my child(ren) _____

I am aware that it is my responsibility to provide the sunscreen to Gan Israel Day Camp.

In order to apply any other lotions or topical treatments to your child, we must have either a permission slip from you (the parent) or a prescription from their doctor.

Parent Name (Print)

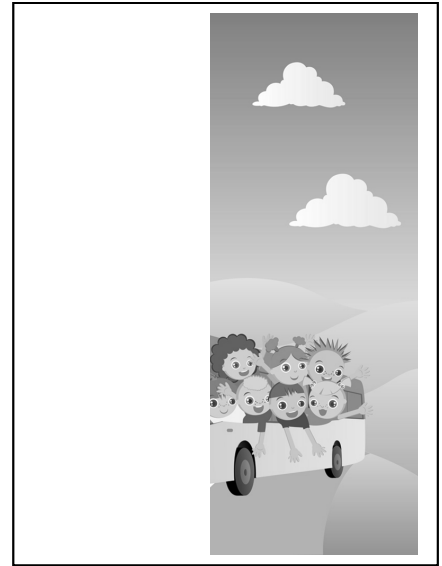
Parent Signature

_____ (Date) _____



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Israel Day Camp Field Trip Permission



Student Name _____

Birthdate _____

I give my permission for my child _____ to be accompanied by members of the faculty/staff of Camp Gan Israel on trips off-campus for field trips or lunch outings during 2010 Summer Camp.

Parent Name (Print)

Parent Signature

_____ (Date) _____

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

(1) Complete all items on this side of the form. Sign and date where indicated.

(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

When parents cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt.# City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt.# City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt.# City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____
Address _____

Street/Apt.# City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____
Street/Apt.# City State Zip Code

Mother's Name _____ Home Telephone _____
Last First

Mother's Employer/School _____
Name Address

Mother's Home Address (If different from above) _____
Street/Apt.# City State Zip Code

Work Telephone _____ Cellular Phone _____ Beeper _____

Father's Name _____ Home Telephone _____
Last First

Father's Employer/School _____
Name Address

Father's Home Address (If different from above) _____
Street/Apt.# City State Zip Code

Work Telephone _____ Cellular Phone _____ Beeper _____

Name of Person Authorized to Pick Up Child (daily)

_____ Relationship to Child
Last First

Address _____
Street/Apt.# City State Zip Code

ANNUAL UPDATES _____
(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

OCC 1214 (Revised 7/05) - Side 1 of 2 - All previous editions are obsolete.

INSTRUCTIONS TO PARENT:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.

(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s):

Medications currently being taken by your child:

Date of your child's last tetanus shot:

Allergies/Reactions:

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for:

(2) If signs/symptoms appear, do this:

(3) To prevent incidents:

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED:

COMMENTS:

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

Name of Health Practitioner

Date

Signature of Health Practitioner

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Telephone Number

OCC 1214 (Revised 7/05) - Side 2 of 2 - All previous editions are obsolete.