

Summer Camp

(631) 435-3215

Shepherd's Gate Registration

1725 Brentwood Rd, Brentwood NY 1171

www.shepherdsgateacademy.com

July 5th – August 18th

Date ___/___/2023

Parent Information

Parent/Guardian 1	Parent/Guardian 2
Mother's Full Name/Nombre Completo de Madre:	Father's Full Name/Nombre Completo de Papa:
Mother's Cell Phone/ Celular de Madre: ()	Father's Cell Phone/ Celular de Padre: ()
Mother's Employer/ Empleador de Madre:	Father's Employer/ Empleador de Papa:
Position/Posicion:	Position/Posicion:
Mother's work Phone/Telefono de Trabajo de Mama: ()	Father's Work Phone/Telefono de Trabajo de Papa: ()
Mother's Email/ Correo Electronico de Mama:	Father's Email/ Correo Electronico de Papa:
Address/Direccion:	
Parent: Private <input type="checkbox"/> DSS Approved <input type="checkbox"/> DSS Applying <input type="checkbox"/> 1199 <input type="checkbox"/> Scholarship <input type="checkbox"/> Other <input type="checkbox"/>	

If Parents are Separated or Divorced with whom does the child live? _____

Enrollment - July +August**Summer Camp Weeks Desired**

Child's Name Nombre del Nino/a	D.O.B	Gender Genero	Age Edad	All 7 Weeks	1	2	3	4	5	6	7

Emergency Contacts

Name	Phone Number	Relationship/Relacion	Allowed to remove premises? Autorizado a llevarse Nino/a
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
Physician		Doctor	Yes <input type="checkbox"/> No <input type="checkbox"/>

Confirmation of Summer Camp week will be provided only after full payment is received. Guarantee of weeks is assured only on a first-paid first-reserved basis. Every child must pay a non-refundable registration fee of \$200. After a week is paid for, that week belongs to the parent/guardian and the paid tuition thereof is not refundable.

Please check one & Initial: Yes _____ No _____ I give permission for pictures to be taken for use by Shepherd's Gate to be displayed in yearbooks, brochures and website purposes, not to be shared with any outside organization

How Did you hear about us? _____

Has your child attended any other Shepherd's gate program? _____

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Date ___/___/2023

Charges- Internal Use Only	Amount		Internal use only Weeks reserved
	Due	Paid <u>Enter</u>	
Non-refundable Registration Fee Number of children: ___ x \$200.00 =			Excel <input type="checkbox"/> Procure <input type="checkbox"/> File <input type="checkbox"/> ___
School Age-Full Day 5-12 years 1 st Child: \$250 x weeks ___ = 2 nd Child: \$240 x weeks ___ =			
School Age- Half day 5-12years 1 st Child: \$150 x weeks ___ = 2 nd Child: \$150 x weeks ___ =			(Please Check Program) AM- 9:00 AM-12 PM <input type="checkbox"/> PM- 1:00 PM-4:00 PM <input type="checkbox"/>
Pre-K- Full Day 3.5-4.5 years 1 st Child: \$250 x weeks ___ = 2 nd Child: \$240 x weeks ___ =			
Pre-K- Half Day 3.5-4.5years 1 st Child: \$150 x weeks ___ = 2 nd Child: \$150 x weeks ___ =			(Please Check Program) AM- 9:00 AM-12 PM <input type="checkbox"/> PM- 1:00 PM-4 PM <input type="checkbox"/>
Full Day Daily Rate \$65 X ___ Days X ___ Weeks= \$15 X ___ Trips=			M T W Th F
Half Day Daily Rate \$40 X ___ Days X ___ Weeks =			M T W Th F
Extended hrs: before 9:00 AM or after 4:00 PM One Session (AM or PM) \$60 x wks ___ (per family) Both AM and PM: \$100 x wks ___ (per family) =			AM Hours <input type="checkbox"/> PM Hours <input type="checkbox"/> (Please Check) Both <input type="checkbox"/>
T-SHIRTS S -M-L SIZE #			\$15 PER SHIRTS
Total			Balance-

Payment Arrangement: A Copy must be given to the client & Accounting Department Date: ___/___/___

Layaway Plan _____ Payment Plan _____ C.C/Cash/Check/Plan _____

Shepherd's Gate Personnel: _____ Date: ___/___/___

Parent/Guardian Signature: _____ Date: ___/___/___

TSHIRT ORDER: TOTAL \$ _____ PAID ON ___/___/___ STAFF INITIALS _____

Total # OF T-SHIRTS- _____ CXS _____ CS _____ CM _____ CL _____ CXL _____ AS _____ AM _____ AL _____ AXL _____

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***Medical Alert*:**

Does your child have allergies? Y or N . If yes, to what _____ Milk, eggs, bee sting, peanuts, etc.

What precautions should be observed? _____

Please clearly state any dietary restrictions. _____

Is your child on daily medication? Y or N if yes, please describe medication and regime (Ritalin, insulin, etc.)

Fully describe in writing any physical or emotional limitations: _____

***Medical Emergency*:** In case of injury or illness to my child, if I cannot be contacted, I hereby grant Shepherd's Gate permission to seek and apply medical aid appropriate to prudent care, this includes calling 911 for proper care if required

X _____

Statement of Cooperation

It is my understanding that the policy for Shepherd's Gate is to make no refunds on registration fees. I give Shepherd's Gate permission for my child to take part in all school activities, including bus trips, sports activities and school-sponsored trips away from the school premises. I further agree to hold the school and its agents harmless for any liability to my child or any guardian or parent thereof because of any claims on behalf of my child be taken against Shepherd's Gate or any employee or agent thereof, on my child's behalf and the school or its agent not be found at fault, I agree to pay any attorney fees, court fees, damages or other costs that Shepherd's Gate or its agent should incur to defend itself against such action.

This Statement of Cooperation will be in effect for as long as my children listed (or others to be enrolled) attend Shepherd's Gate Summer Camp.

I understand that should my marital status change that it is my responsibility to have a corrected Statement of Cooperation signed and updated and delivered to Shepherd's Gate. Shepherd's Gate admits children of any race, color, religion, and national or ethnic origin.

Mother: _____ Father: _____

Guardian: _____ Date: ____/____/____

Signature for statement of cooperation Required

Late Fee: I understand that there is a \$1 per minute late fee for lateness after 4 PM if late pick up has not been prearranged
x _____

Registration Orientation Checklist: For Office Use Only

S.G News Subscription _____ **Website Membership** _____ **Camp Info Packet & Calendar** _____

Payment Information _____ **Camp Policies** _____ **Staff Initials** _____

Dss case worker _____ Weekly Parent Fee: \$ _____ if you need Before /After Care you are able to only select either AM or PM . if you need both Before/Aftercare you must pay \$60 per week.

Phone Numer: ()

Coverage Start: Day ____/____/____ End Day: ____/____/____

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Field Trip Transportation Agreement

I, _____, give permission for my child care provider, or any approved
(Name of parent)

employee of the above program, to transport my child(ren)

1. _____ 2. _____ 3. _____
(Name(s) of child(ren) (Name(s) of child(ren) (Name(s) of child(ren)

for the following field trips (Please Initial Below): Trip dates are subject to change due to weather or other circumstance.

Parent Initials	Date	Trip
_____	_____	- TRIP TBD
_____	_____	- TRIP TBD
_____	_____	- TRIP TBD
_____	_____	- TRIP TBD
_____	_____	- TRIP TBD
_____	_____	- TRIP TBD

It is agreed that:

1. The caregiver will never leave my child(ren) unattended in any motor vehicle or other form of transportation.
2. Each child will board or leave a vehicle from the curb side of the street.
3. My child(ren) will be secured in safety seats or by safety belts as appropriate for the age of the child(ren) in accordance with the law.
4. Any motor vehicle used to transport my child(ren) will have current registration and inspection stickers, and must be operated by a person who is at least 18 years of age and possesses a valid driver's license.
5. Staff to child ratios will be maintained throughout the course of the trip. The driver of the bus will not be considered as part of the ratios.

(Parent or Guardian)

___/___/___
(Date)

Sunscreen Permission

The child care provider or her substitutes have my permission to apply sunscreen to my child _____, as needed. I understand I am still responsible for sending my child with Sunscreen already applied daily.

My signature below signifies that I am aware of and agree with the provider's policy of applying sunscreen as needed, and that I am still responsible for applying it to my child prior to drop off every day during the months needed.

(Parent or Guardian)

___/___/___
(Date)

(Office Personnel)

___/___/___
(Date)

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PRIVATE PHYSICIAN'S REPORT

OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

DATE _____ 20 ____

NAME OF SCHOOL _____ GRADE _____ HOMEROOM _____

NAME OF CHILD _____ DATE OF BIRTH _____ SEX [] M [] F
Last First Middle

ADDRESS _____
No. and Street City or Post Office Borough or Township County State Zip Code

MEDICAL HISTORY
IMMUNIZATIONS AND TESTS

Table with columns: VACCINE, DOSES (1-5), BOOSTERS & DATES. Rows include Diphtheria and Tetanus, Polio, Measles, Mumps, Rubella, Hepatitis B, HIB, Varicella, and Other.

- [] MEDICAL EXEMPTION The physical condition of the above named child is such that immunization would endanger life or health
[] RELIGIOUS EXEMPTION (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

If Applicable:

Table for Tuberculin Tests with columns: Tuberculin Tests Date Applied, Arm, Device, Antigen, Manufacturer, Signature. Includes a section for Date Read, Results (mm), and Signature.

Follow-Up of significant tuberculin tests:
Parent/Guardian notified of significant findings on _____ Date _____

Result of Diagnostic Studies: _____ Date _____

Preventive Anti-Tuberculosis - Chemotherapy ordered. No [] Yes [] _____

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Significant Medical Conditions

	Yes	No	If Yes, Explain
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical Dependency.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuromuscular Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic Condition.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Illness.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Specify).....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify _____

• Height (inches)				
• Weight (pounds) BMI				
• Pulse ()				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes/Vision				
• Ears/Hearing				
• Nose and Throat				
• Teeth and Gingiva				
• Lymph Glands				
• Heart — Murmur, etc.				
• Lung — Adventitious Findings				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

 Date of Examination

 Signature of Examiner

 Address

 Print Name of Examiner

 Telephone Number

Automated Payment Processing



Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

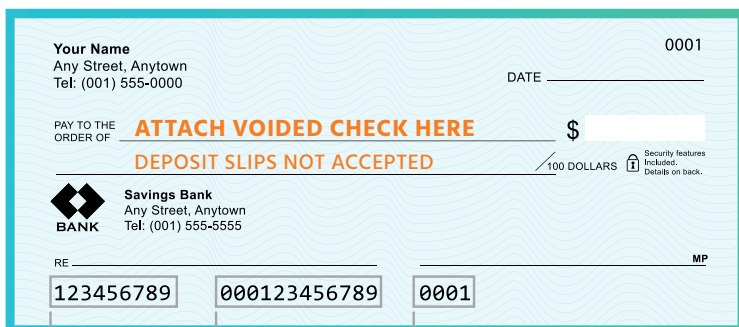
COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name	Phone #		
Cardholder Address	City	State	Zip
Account Number	Expiration Date		
Cardholder Signature	Date		

SECTION B (Bank Account)

Your Name	Phone #			
Address	City	State	Zip	
Bank or Credit Union Name	Bank or Credit Union Address	City	State	Zip
Routing Transit Number (see sample below)	Account Number (see sample below)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings	
Authorized Signature	Date			



ROUTING NUMBER ACCOUNT NUMBER CHECK NUMBER

FOR OFFICIAL USE ONLY

Date Received

Employee Signature

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