Summer Camp Shepherd's Gate Registration July 5th to August 19th

1725 Brentwood Road, Brentwood, New York 11717

(631) 435-3215 Web site: www.shepherdsgateacademy.com Today's Date __/__/2022

Parent/Guardian Bill To:	**Parent/Guardian Phone:**
Mother: First Name: _____ Last Name:	Mothers Employer: _____ Position:_____Location:_____
Father First Name: _____ Last Name:	Work Phone: (631)
Address:	Fathers Employer: _____
City: ZIP:	Work Phone: (631)_____ Position:_____Location:_____
Home Phone: (631)	Mom's Cell Phone:
Home E-Mail:	Dad's Cell Phone:

Parent: Private ☐ DSS Approved ☐ DSS Applying ☐ 1199 ☐ Scholarship ☐ Other ☐

If parents are separated or divorced with whom does the child live? _____

Emergency and Alternate Contact Names

Contact Name	**Phone Number**	**Relationship**	[1]Remove from premises Authority?
			Yes / No
			Yes / No
			Yes / No
Physician:		Addr:	

Enrollment – July +August

Child's Name	DOB	AGE		**Summer Camp Week Desired**						
			All 7 weeks	**1**	**2**	**3**	**4**	**5**	**6**	**7**
1)										
2)										
3)										

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 circle 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.

Charges- Internal Use Only	**Amount**		**Internal use only**
	Due	**Paid Enter**	**Weeks reserved**

How did your hear about us?_____

Has your child attended any other Shepherds's Gate program?_____

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Non-refundable Registration Fee Number of children: _____ x $200.00 =					Excel ___ Procare ____ File ____
School Age-Full Day 5-12 years 1st Child: $200 x weeks ___ = 2nd Child: $190 x weeks___ = $15 X _____ Trips=					
School Age- Half day 5-12years 1st Child: $125 x weeks ___ = 2nd Child: $125 x weeks___ =					**(Please Circle Program)** **AM- 9:00 AM-12 PM** **PM- 1:00 PM-4:00 PM**
Pre-K- Full Day 3.5-4.5 years 1st Child: $200 x weeks ___ = 2nd Child: $190 x weeks___ =					
Pre-K- Half Day 3.5-4.5years 1st Child: $125 x weeks ___ = 2nd Child: $125 x weeks___ =					**(Please Circle Program)** **AM- 9:00 AM-12 PM** **PM- 1:00 PM-4 PM**
Full Day Daily Rate $60 X _____ Days X _____Weeks= $15 X _____ Trips=					**M T W Th F**
Half Day Daily Rate $35 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** **PM Hours (Please Circle)** **Both**
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 ☐ Check/Plan ☐

Shepherd's Gate Personnel: _____ Date: ___/___/2022

Parent/Guardian Signature: _____ Date: ___/___/2022

TSHIRT ORDER: TOTAL $_____ PAID ON _____ STAFF INITIALS_____

Total # OF T-SHIRTS-_____ CXS____CS_____CM_____CL____CXL____ AS____AM____AL____AXL____

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. _____

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Is your child on daily medication? **Y OR N** If yes, describe medication and regimen (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. _____

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: _____/_____/2022

Signature for Statement of Cooperation Required

I understand that there is a $1 per minute fee for lateness after 4 pm if late pick up has not been prearranged _____

Additional Information:

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 or Aftercare you are able only to select either AM or PM_____. If you need both Before/Aftercare you must pay $60 per week._____.
Phone Number: (631) _____ Coverage: Start Day ___/___/2022 End Day: __/___/2022

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Field Trip Transportation Agreement(Pending Covid Restrictions)

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

employee of the above program, to transport my 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)

Shepherd's Gate Academy Before and After school Care
1725 Brentwood Rd
Brentwood NY 11717
(631)-435-3215-Office
(631)-435-0502- Fax
www.sgbac.org

PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

DATE _____ 20 _____

NAME OF SCHOOL **Shepherd's Gate Academy** GRADE _____ HOMEROOM _____

NAME OF CHILD	DATE OF BIRTH	SEX
Last First Middle		☐ M ☐ F

ADDRESS

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

MEDICAL HISTORY

IMMUNIZATIONS AND TESTS

VACCINE	Enter Month, Day, And Year Each Immunization Was Given DOSES			BOOSTERS & DATES	
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, Td	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	Varicella Disease or Lab Evidence Date: _____		
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:

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	**Results (mm)**		**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 _____ Date

(Continued on Back)

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Significant Medical Conditions (✓)

	Yes	No	If Yes, Explain
Allergies	☐	☐	
Asthma	☐	☐	
Cardiac	☐	☐	
Chemical Dependency	☐	☐	
Drugs	☐	☐	
Alcohol	☐	☐	
Diabetes Mellitus	☐	☐	
Gastrointestinal Disorder	☐	☐	
Hearing Disorder	☐	☐	
Hypertension	☐	☐	
Neuromuscular Disorder	☐	☐	
Orthopedic Condition	☐	☐	
Respiratory Illness	☐	☐	
Seizure Disorder	☐	☐	
Skin Disorder	☐	☐	
Vision Disorder	☐	☐	
Other (Specify)	☐	☐	

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 _____

Report of Physical Examination (✓)

	Normal	Abnormal	Not Examined	Comments
• 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 **Print** Name of Examiner

_____ _____
Address 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) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature

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