Galena ARC – 2022 Summer Camp Paper Work Check List

Parents return to ARC:

Memo
To: Summer Camp Parents
Date: March 28, 2022
Re: Summer Camp Paper Work

Parents:

The following is a check list for registration paperwork:

1. Summary of Licensing Standards for Day Care Centers (small booklet) _____(If we don't already have it)
2. Application/ Record of Child Information_____(If we already don't have it)
3. Consents to Day Care Providers_____(If we already don't have it)
4. Physical Form_____ (If we already don't have it)
   Make sure it includes: **Varicella, lead questionnaire & TB Skin Test** (Note: The Lead and TB test may be waived with physician's permission. Have your physician state and sign to this effect on the form).
5. Contract _____
6. Handbook_____ (Please read the entire handbook, sign page 14 and return it to the ARC).
7. _____A certified copy of Birth Certificate (or other reliable proof of identity and age of child). (If we already don't have it)
8. ARC Swimming Consent Form: _____
9. ARC Sunscreen Form: _____
10. City of Galena Pool Pass Info Sheet_____ (to ARC if registered by 4/15/22) City of Galena Pool Pass required for all children unless only attending Tues/Thurs. If registering after 4/15/22 you will need to register at City Hall.
11. City of Galena Swimming Lessons Registration form_____ (to ARC if registered by4/15/22 Form is required if attending swimming lessons. Lessons are from 7/5/-7/15/2022. 11:15-11:55**(ARC will be closed on July 5th)** If registering after 4/15/22 registration at City Hall is required
12. . First week and all registration fees paid prior to attendance_____
    One check made payable to Galena ARC.

We must have all documentation before we can allow your child to attend the first day of Summer Camp. If you have any questions please feel free to contact me at 815-777-2248, or email me at childcaredirector@galenaarc.org
Thanks, Brenda

ARC 2022 SUMMER CAMP REGISTRATION FORM

Child (ren)'s Name(s):

1) _____ Age: _____

2) _____ Age: _____

3) _____ Age: _____

Parents/Guardians:

Name(s)_____

Address_____ City_____

Phone Numbers:

Home: _____

Cell: Parent 1: _____ Parent 2: _____

Work: Parent 1: _____ Parent 2: _____

Email Address:_____

Pick up:

Person(s) allowed to pick-up child(ren) when parents/guardians are not available:

Name: _____ Ph: _____ Relationship: _____

Name: _____ Ph: _____ Relationship: _____

Emergency Contact:

When parents/guardians cannot be immediately reached, this person is also allowed to pick up

Name: _____ Ph: _____ Relationship: _____

Preferred Physician/Hospital_____

Does your child (ren) have any known allergies/health concerns:_____

_____

Does your child(ren) take any routine medications_____ Name: _____

Date: _____

CONTRACT FOR SERVICES
SUMMER CAMP 2022

I,_____ (person placing child(ren)) do hereby enter into the following Contract for Services with the Galena Art and Recreation Center (ARC) for the Summer Camp Program for_____(child(ren)'s names)

Beginning(date)_____and ending(date)_____
(Last day of summer camp is 8/5)

Parents: you must check the weeks your child(ren) will be attending.

Week	Theme	Dates	Please ✓ if attending:
1	Garden Week	May 31-June 3	
2	Kids in the Kitchen Week	June 6-10	
3	Summer Olympics Art with Ms. Liz Bears Pirates Lions 14th	June 13-17	
4	Around the World Week	June 20-24	
5	4th of July Week	June 27-July 1	
6	Hometown Hero/ Kindness Week **Swim Lesson Week 1**	July 5-8	
7	Luau &Water Week **Swim Lesson Week 2**	July 11-15	
8	Farm Week Art with Ms. Liz Bears Pirates Lions 19th	July 18-11	
9	Space & Stars Week	July 25-29	
10	Disney Week	August 1-5	

My child(ren) shall attend the Summer Camp Program following the set weekly schedule below, and I understand this will be their committed schedule for the summer. I agree to pay the following weekly fees every Friday **(paying in advance for the next week of care)** or a daily late fee will be charged. I understand that payment is non-refundable, with no credit allotted for unused days. I also understand that I will be billed monthly for field trip fees/activity fees/lunch fees in addition to my weekly fees on days my child(ren) attend.
My child(ren)'s weekly schedule and fees will be:

FULL DAY PROGRAM:

5 DAY WEEK: M-F_____	•____$140/week (1 child)	•____$252/week (2 kids)	•___$364/week (3 kids)
4 DAY WEEK: M T W TH F	•____$112/week (1child)	•____$202/week (2kids)	•____$290/week (3kids)
3 DAY WEEK: M T W TH F	•____$90. /week (1 child)	•____$162/week (2 kids)	•___$270/week (3kids)
2 DAY WEEK: M T W TH F	•____$65/week (1 child)	•____$117/week (2 kids)	•___$162/week (3 kids)

HALF DAY PROGRAM:

3 DAY POOL: Monday, Wednesday & Friday (12-6pm)

•_____$50/week (1child) •_____$90/ week (2kids) •_____$162/week (3kids)

HALF DAY PROGRAM:

TUESDAY/THURSDAY (7-12am)

•_____$40/week (1child) •_____$72/ week (2kids) •_____$129/week(3kids)

DROP IN PROGRAM: No guaranteed space/24 hr. advance confirmation required

•____$45/day per child

I (we) understand and agree to abide by the terms as stated in this contract. This contract must be turned in with the handbook receipt, stating that I (we) have read and agree to follow all ARC policies. I also understand that from time to time new policies may be implemented or changed as needed. I understand that I will be notified of such changes.

Signature_____Date:_____
Parent/Guardian

Office Use Only:

_____**First Week Fee (from above fee schedule) Payment reserves your child's spot in the program**
_____**Registration Fee** ($25-individual; $40-Family: 1 time annual fee paid at time of summer program)
_____**Sunscreen Fee ($20 /child – paid for all children regardless of schedule)**
_____**Pool cost ($40/child-Required for all children attending M/W/F afternoon pool days)**
_____**Swim Lesson Fee ($40/child – if attending swim lessons during ARC session)**

_____ **Total Needed to Start Summer Camp: Cash/Check#**_____ **Date** _____

Galena ARC Swimming Consent Form

As part of our summer camp program we will be going to the Alice T. Virtue water park on Monday, Wednesday & Friday each week. The children will be transported to the water park via School Bus the cost of this School bus ride is figured into your weekly tuition. At the water park the children will be divided into three groups to be supervised by ARC staff. The children will be divided according to parent request, based on children's swim abilities and staff comfort level. The ARC reserves the right to make the final decision on swim group placement. Please choose the group you would like your child to be assigned to at the pool.

Child's Name _____

_____ *PURPLE BRACELETS:* I request my child be assigned to the **PURPLE** swimming group that remains in the kiddie pool, unless staff takes them down the slide. This group will always move as a group and be under direct supervision of an ARC staff. (All 3-year-olds will wear a purple bracelet.)

_____ *YELLOW BRACELETS:* I request my child be assigned to the **YELLOW** swimming group that remains in the shallow end of the pool, unless staff takes them down the slide. This group will always move as a group and be under direct supervision of an ARC staff. (All 4-year-olds will wear yellow bracelets; floatie recommended)

_____ *RED BRACELETS:* I request my child be assigned to the **RED** swimming group that may use the 4ft area of the pool. They may also use the large blue water slide without assistance. This group will be assigned a teacher and children must be mature enough to check in with/return to the group after they finish going off the slide, using the restroom, etc.

_____ *BLUE BRACELETS:* I request my child be assigned to the **BLUE** swimming group. This group will have the freedom to use all areas of the pool without assistance, including the diving board and the red slide in the 12ft area of the pool. This group will be responsible to check in at the "ARC camp" at the beginning of each rest period with a teacher and stay with the group during rest periods.

Parent/ Guardian Signature_____

Date _____

Galena ARC Child Sunscreen Form

Galena Art & Recreation Center requires that all children enrolled in center programs to wear sunscreen when involved in water and extended outdoor activities. The ARC has collected a sunscreen fee and will purchase sunscreen for each child and will ensure its use.
In the beginning of the season children are encouraged to wear a light weight t-shirt to protect them while swimming. If parents feel this is necessary they must provide the t-shirt and inform the teacher of their choice.

I give permission for the Galena Art and Recreation Center staff to oversee the use and application of sunscreen by my child.

Child's Name: _____

Parent/ Guardian Signature: _____ Date

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian	Telephone # Home		Work

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or DTaP						
Tdap, Td or Pediatric DT (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps, Rubella				Comments: * indicates invalid dose		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature Title Date

Signature Title Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.

Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease Signature Title

3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps ☐Rubella ☐Varicella Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.

**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____

Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

Last First Middle | Birth Date Month/Day/Year

HEALTH HISTORY — TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	Yes / No	List:	MEDICATION (Prescribed or taken on a regular basis.)	Yes / No	List:
Diagnosis of asthma?	Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Child wakes during night coughing?	Yes No				
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? ____ Glasses ☐ Contacts ☐ Last exam by eye doctor ____			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Information may be shared with appropriate personnel for health and educational purposes.		
Ear/Hearing problems?	Yes No		Parent/Guardian Signature		Date
Bone/Joint problem/injury/scoliosis?	Yes No				

PHYSICAL EXAMINATION REQUIREMENTS — Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE if < 2-3 years old | HEIGHT | WEIGHT | BMI | BMI PERCENTILE | B/P

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes☐ No☐ And any two of the following: Family History Yes ☐ No ☐ Ethnic Minority Yes☐ No ☐ Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ At Risk Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ Blood Test Indicated? Yes ☐ No ☐ Blood Test Date Result

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ Test performed ☐ Skin Test: Date Read Result: Positive ☐ Negative ☐ mm_____

Blood Test: Date Reported Result: Positive ☐ Negative ☐ Value

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears		Screening Result:	Gastrointestinal		
Eyes		Screening Result:	Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Exam		
Cardiovascular/HTN			Nutritional status		
Respiratory		☐ Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			Other		
NEEDS/MODIFICATIONS required in the school setting			DIETARY Needs/Restrictions		

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Modified ☐

Print Name (MD,DO, APN, PA) Signature Date

Address Phone