NYC ELITE SUMMER CAMP 2020 REGISTRATION FORM

NYC Elite Tribeca
P: 212-334-3628 F: 212-334-1179
Email : tribeca@nycelite.com

NYC Elite UES
P: 212-289-8737 F: 212-289-7177
Email : ues@nycelite.com

NYC Elite UWS
P : 212-775-1177 F: 212-775-1977
Email : uws@nycelite.com

CAMPER INFORMATION

Camper Name _____ Age _____ Sex_____ Birthdate _____/_____/_____

Parent/Guardian _____ Home phone _____ Cell _____

Address _____City _____ State _____ Zip _____

Email Address _____

Emergency contact (other than parent) _____ Phone _____Relation to child _____

MEDICAL INFORMATION

Child's doctor _____ Phone _____ Dentist _____ Phone _____

Medical Insurance Carrier _____ ID # _____

Medication or Food Allergies _____ ***Please notify NYC Elite of any dietary restrictions.***

Are there any known physical limitations or developmental concerns? _____

THE ATTACHED DEPARTMENT OF HEALTH FORM MUST BE USED. We cannot accept a doctor's form. Without the Department of Health form, your camper will not be allowed to participate.

PAYMENT INFORMATION

We require full payment upon registration for all camp weeks.
Please put an "x" next the location & weekly option in which you would like to register.

Choose NYC Elite location: ☐ **Tribeca** ☐ **UES** ☐ **UWS**

Half Day Camp: (9:00am-12:00pm) (3 & 4 Years)

- ☐ **H.D. Option 1**: Monday – Friday (5 days) $520
- ☐ **H.D. Option 2:** Tue & Thurs. (2 days) $208
- ☐ **H.D. Option 3:** Mon/Wed/Fri (3 days) $312

Full Day Camp: (9:00am-3:30pm) (5 years and up)

- ☐ **F.D. Option 1**: Monday – Friday (5 days) $745
- ☐ **F.D. Option 2:** Tue & Thurs. (2 days) $298
- ☐ **F.D. Option 3:** Mon/Wed/Fri (3 days) $447

Credit Card Information :

AMEX / VISA / MC / DISCOVER

Card number:_____

Exp. Date ____/_____ Sec Code : _____

Full payment amount _____

Please check the week(s) you wish to reserve for your camper.

6/15-6/19	6/22-6/26	6/29-7/3	7/6-7/10	7/13-7/17	7/20-7/24	7/27-7/31	8/3-8/7	8/10-8/14	8/17-8/21	8/24-8/28	8/31-9/4
		CLOSED									

NYC Elite summer camp swims weekly at a local pool. The depth of the pool is four feet. In addition to the pool's lifeguard, NYC Elite provides adult chaperones. Please notify us of any reason your child cannot participate in swimming activities. **Does your child know how to swim? ____Y/N_____(FULL DAY ONLY)**

ASSUMPTION OF RISK, WAIVER OF LIABILITY, MEDICAL AUTHORIZATION

WARNING: By the very nature of the activity, gymnastic and dance carry a risk of physical injury. No matter how careful the student and instructor are, no matter how many spotters are used, no matter what height is used or what landing surface exists, the risk cannot be eliminated. Reduced, yes, but never eliminated. The risk of injury includes minor injuries such as bruises and more serious injuries such as broken bones, dislocations and muscle pulls. The risk also includes, and always includes, catastrophic injuries such as permanent paralysis or even death from landings or falls on the back, neck, or head.
You hereby agree to waive any claims or rights that you might otherwise have to sue us (NYC Elite Gymnastics, Inc.), our employees, owners, or officers for injuries that may occur as a result of any activity conducted at NYC Elite. You assume all liability and risk.
If injury should occur to the above named while participating in any NYC Elite activity, I hereby authorize NYC Elite to make use of my insurance policy. I understand that payment will be made directly to the doctor or hospital. Should the insurance not make full payment, I will accept the remainder of the responsibility.

Signature _____ Date _____

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* __ __ / __ __ / __ __ __ __

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough | State | Zip Code | School/Center/Camp Name | District Number __ __ __ __ | **Phone Numbers** *Home* _____ *Cell* _____ *Work* _____

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** ☐ **Foster Parent** Last Name | First Name

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

Dietary Restrictions

☐ None ☐ Yes *(list below)*

PHYSICAL EXAMINATION

Height _____ **cm** (__ __ %ile)

Weight _____ **kg** (__ __ %ile)

BMI _____ **kg/m²** (__ __ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (__ __ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl	
☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development
☐	☐	Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language
☐	☐	Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	Behavioral

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__/__/__	_____ µg/dL
	__/__/__	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__/__/__	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	_____ g/dL _____ %

	Date Done	*Results*
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration _____mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* ___/___ *Left* ___/___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus	__/__/__	__/__/__	__/__/__	__/__/__
DTP/DTaP/DT	__/__/__	__/__/__	__/__/__	__/__/__
	__/__/__	__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__	__/__/__

Influenza	__/__/__	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__		
Td	__/__/__	__/__/__	__/__/__	__/__/__
Tdap __/__/__	Hep A	__/__/__	__/__/__	
Meningococcal	__/__/__	__/__/__		
HPV	__/__/__	__/__/__	__/__/__	
Other, *specify:* _____	__/__/__	; _____		__/__/__

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __/__/__

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

_____ __ __ __ __

_____ __ __ __ __

_____ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __ __ __

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

DOHMH ONLY **PROVIDER I.D.**

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: __/__/__ I.D. NUMBER

REVIEWER:

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian

Drop Off and Pick Up Policy

In the interest of the safety of all NYC Elite participants, the following protocol shall be followed for all children being dropped off and picked up from any NYC Elite Camp.

Notification of Authorization:
In the event that a parent/guardian is not picking up your gymnast from camp, NYC Elite must be notified in advance, in writing or by adding them to the guardian section of the family details page of their parent portal, persons whom are approved to pick up your child from NYC Elite. Verbal permission may be given by phone, but must be followed up by an email to the site manager. Wherever possible, we will not release a child unless we have written consent from a parent or guardian. It is the responsibility of the parent/guardian to inform NYC Elite of any updates that need to be made to the list of authorized individuals, and to make changes to their parent portal as needed.

Drop Off and Release of a Child
All parents and/or authorized individuals are to:

- Clearly sign-in the child on the provided sheet. Space will be provided to put the name of the authorized person who will be picking up the child/children.
- Valid photo ID must be presented when signing a child out of camp. This ID will be cross checked by NYC Elite staff to ensure that the person signing the child out is who they claim to be.

Parent/Guardian Authorization for Pick up Form

I _____ hereby authorize the following individuals to pick
(name of parent/guardian)

up _____ from NYC Elite:
(full name(s) of child/children)

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____
4. Name: _____ Phone: _____
5. Name: _____ Phone: _____
6. Name: _____ Phone: _____

_____ _____
Parent name Parent Signature

_____
Date

My signature on this page indicates that I have read, understand, and agree to adhere to the drop off and pick up policy as set out by NYC Elite.