



# NYC ELITE SUMMER CAMP 2019 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) \$480
- H.D. Option 2:** Tue & Thurs. (2 days) \$192
- H.D. Option 3:** Mon/Wed/Fri (3 days) \$288

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

- F.D. Option 1:** Monday – Friday (5 days) \$710
- F.D. Option 2:** Tue & Thurs. (2 days) \$284
- F.D. Option 3:** Mon/Wed/Fri (3 days) \$426

#### 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.

6/17-6/21	6/24-6/28	7/1-7/5	7/8-7/12	7/15-7/19	7/22-7/26	7/29-8/2	8/5-8/9	8/12-8/16	8/19-8/23	8/26-8/30
		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

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## TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____
Child's Address			Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other
City/Borough	State	Zip Code	School/Center/Camp Name	District _____ Number _____
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Foster Parent	Last Name	First Name	Phone Numbers Home _____ Cell _____ Work _____

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

<b>Birth history (age 0-6 yrs)</b> <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____ <b>Allergies</b> <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____	<b>Does the child/adolescent have a past or present medical history of the following?</b> <b>Asthma (check severity and attach MAF/Asthma Action Plan):</b> <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <i>If persistent, check all current medication(s):</i> <input type="checkbox"/> Inhaled corticosteroid <input type="checkbox"/> Other controller <input type="checkbox"/> Quick relief med <input type="checkbox"/> Oral steroid <input type="checkbox"/> None <input type="checkbox"/> Attention Deficit Hyperactivity Disorder <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Chronic or recurrent otitis media <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Other (specify) _____	<b>Medications (attach MAF if in-school medication needed)</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____ <b>Dietary Restrictions</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____
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*Explain all checked items above or on addendum*

<b>PHYSICAL EXAMINATION</b> Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m <sup>2</sup> (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____	<b>General Appearance:</b> <table border="0"> <tr> <td><i>Nl Abnl</i></td><td><input type="checkbox"/> HEENT</td><td><i>Nl Abnl</i></td><td><input type="checkbox"/> Lymph nodes</td><td><i>Nl Abnl</i></td><td><input type="checkbox"/> Abdomen</td><td><i>Nl Abnl</i></td><td><input type="checkbox"/> Skin</td><td><i>Nl Abnl</i></td><td><input type="checkbox"/> Psychosocial Development</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/> DENTAL</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Lungs</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Genitourinary</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Neurological</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Language</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/> Neck</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Cardiovascular</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Extremities</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Back/spine</td><td><input type="checkbox"/></td><td><input type="checkbox"/> Behavioral</td> </tr> </table> <b>Describe abnormalities:</b> _____ _____	<i>Nl Abnl</i>	<input type="checkbox"/> HEENT	<i>Nl Abnl</i>	<input type="checkbox"/> Lymph nodes	<i>Nl Abnl</i>	<input type="checkbox"/> Abdomen	<i>Nl Abnl</i>	<input type="checkbox"/> Skin	<i>Nl Abnl</i>	<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/>	<input type="checkbox"/> DENTAL	<input type="checkbox"/>	<input type="checkbox"/> Lungs	<input type="checkbox"/>	<input type="checkbox"/> Genitourinary	<input type="checkbox"/>	<input type="checkbox"/> Neurological	<input type="checkbox"/>	<input type="checkbox"/> Language	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/> Extremities	<input type="checkbox"/>	<input type="checkbox"/> Back/spine	<input type="checkbox"/>	<input type="checkbox"/> Behavioral
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<b>DEVELOPMENTAL (age 0-6 yrs)</b> <input type="checkbox"/> Within normal limits If delay suspected, specify below <input type="checkbox"/> Cognitive (e.g., play skills) _____ <input type="checkbox"/> Communication/Language _____ <input type="checkbox"/> Social/Emotional _____ <input type="checkbox"/> Adaptive/Self-Help _____ <input type="checkbox"/> Motor _____	<b>SCREENING TESTS</b> <table border="1"> <thead> <tr> <th></th> <th>Date Done</th> <th>Results</th> </tr> </thead> <tbody> <tr> <td><b>Blood Lead Level (BLL)</b> (required at age 1 yr and 2 yrs and for those at risk)</td> <td>____/____/____</td> <td>_____ µg/dL</td> </tr> <tr> <td><b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs)</td> <td>____/____/____</td> <td><input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk</td> </tr> <tr> <td><b>Hearing</b> <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE</td> <td>____/____/____</td> <td><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</td> </tr> <tr> <td><b>Hemoglobin or Hematocrit (age 9-12 mo)</b></td> <td>____/____/____</td> <td>_____ g/dL _____ %</td> </tr> </tbody> </table>		Date Done	Results	<b>Blood Lead Level (BLL)</b> (required at age 1 yr and 2 yrs and for those at risk)	____/____/____	_____ µg/dL	<b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs)	____/____/____	<input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk	<b>Hearing</b> <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE	____/____/____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<b>Hemoglobin or Hematocrit (age 9-12 mo)</b>	____/____/____	_____ g/dL _____ %	<b>Tuberculosis</b> <i>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</i> <table border="1"> <thead> <tr> <th></th> <th>Date Done</th> <th>Results</th> </tr> </thead> <tbody> <tr> <td>PPD/Mantoux placed</td> <td>____/____/____</td> <td>Induration _____ mm</td> </tr> <tr> <td>PPD/Mantoux read</td> <td>____/____/____</td> <td><input type="checkbox"/> Neg <input type="checkbox"/> Pos</td> </tr> <tr> <td>Interferon Test</td> <td>____/____/____</td> <td><input type="checkbox"/> Neg <input type="checkbox"/> Pos</td> </tr> <tr> <td>Chest x-ray (if PPD or Interferon positive)</td> <td>____/____/____</td> <td><input type="checkbox"/> NI <input type="checkbox"/> Not Indicated <input type="checkbox"/> Abnl</td> </tr> <tr> <td><b>Vision</b> (required for new school entrants and children age 4-7 yrs)</td> <td>____/____/____ <input type="checkbox"/> with glasses</td> <td>Acuity Right ____ / ____ Left ____ / ____ Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes</td> </tr> </tbody> </table>		Date Done	Results	PPD/Mantoux placed	____/____/____	Induration _____ mm	PPD/Mantoux read	____/____/____	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	Interferon Test	____/____/____	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	Chest x-ray (if PPD or Interferon positive)	____/____/____	<input type="checkbox"/> NI <input type="checkbox"/> Not Indicated <input type="checkbox"/> Abnl	<b>Vision</b> (required for new school entrants and children age 4-7 yrs)	____/____/____ <input type="checkbox"/> with glasses	Acuity Right ____ / ____ Left ____ / ____ Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes
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<b>IMMUNIZATIONS - DATES</b> CIR Number of Child _____ Hep B _____ Rotavirus _____ DTP/DTaP/DT _____ Hib _____ PCV _____ Polio _____	Influenza _____ MMR _____ Varicella _____ Td _____ Tdap _____ Hep A _____ Meningococcal _____ HPV _____ Other, Specify: _____; _____
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<b>RECOMMENDATIONS</b> <input type="checkbox"/> Full physical activity <input type="checkbox"/> Full diet <input type="checkbox"/> Restrictions (specify) _____ <b>Follow-up Needed</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ <b>Referral(s):</b> <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> Special Education <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	<b>ASSESSMENT</b> <input type="checkbox"/> Well Child (V20.2) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-9 Code _____ _____ _____
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Health Care Provider Signature	Date ____/____/____	<b>DOHMH PROVIDER ONLY</b> PROVIDER I.D. _____
Health Care Provider Name and Degree (print)	Provider License No. and State	<b>TYPE OF EXAM:</b> <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)
Facility Name	National Provider Identifier (NPI)	Comments
Address	City	Date Reviewed: ____/____/____
Telephone (____) _____-____	Fax (____) _____-____	I.D. NUMBER _____
		REVIEWER: _____



## **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.