Goal New York City Summer Program

Contact: Kirk - 914-481-7415 /Fax 914 478-0332
www.mygoalprogram.com
Email: Goalprogram@live.com

APPLICATION

(Please Print)

Pearls Hawthorne ____________ Family School 32______________

Date:________________________

Child's Last Name: ________________________ First Name:________________ M.I. ___ DOB __________

Child Teachers Name: _____________ Child Grade: ____Age: ____ Gender: M__ F__ School: _______

Mother's Full Name/Guardian____

Address____ apt # _____________

City _____________________________________State_________________ Zip _____________

Home Phone _______________________________________ Cell: _________________________

Job Location & Address: _____________________________ City _____________ State ________

Zip _________ Work Phone: __________________ ext _______ Email: ____________________

Father's Full Name/Guardian____

Address____ Apt # ________________

City _______________________ State ________________ zip _____________

Home Phone: __________________________________ Cell: ________________________________

Job Location & Address: ____________________________ City ______________State____________

Zip ________ Work Phone: _____________ Ext ____________ Email:_________________

<u>Emergency Contact List:</u>

Name: _____________________________Phone: _______________________Cell_____________________

Name: _____________________________Phone: _______________________Cell_____________________

Name: _____________________________Phone: _______________________Cell_____________________

Registration Information ***(All children must REGISTER for a minimum of four weeks)***

****

A. Weekly fee: $325 (early bird special).

B. Week 1___Week 2___Week 3___Week 4 ____ Week 5 _____Week 6____ Week 7______

Total Cost:

$325 x Number of weeks ____= $______________

General Information/Special Needs

****

Will your camper require medication during camp hours? **No Yes** If Yes, what **Type?** ____________________
If Yes, **Reason** for medication
:____
Does your have camper have **allergies**? **No Yes** If Yes, please list below **what allergies and treatments for them**:
____
Any **Limits** for your camper? ____
Comments: ____

Please place my child in a group with the following children (note: **subject to availability only**)

___________________ & ____________________________________ & _____________________________

PLEASE READ AND SIGN:
Contract Agreement: A minimum of four weeks per person deposit is due at time of registration plus the registration fee. **The Goal Program** reserves the right to suspend and/or expel any camper. I agree to allow my child to participate in all programs and trips.
I understand that by signing this agreement, I authorize **The Goal Program** to make all necessary emergency decisions including medical treatment, when I or the persons I have listed above cannot be contacted.

Signature of Person Registering Camper____

Date ________/________/_________

For all Fees – Automatic Payment, Cash, Money Order accepted or Please make all checks out to:

GOAL Program

Goal Program - Parent/Legal Guardian Agreement

By "agreeing", I represent and understand that I am the/a parent or legal guardian of the child being enrolled. The child being enrolled is healthy and capable in participating in all **Goal Program** activities and trips. **I will provide the Camp with a completed and signed medical form prior to my child's first day of attendance.** I agree that no medications will be administered by the **Goal Program**, unless provided to **Goal Program** by an authorized parent and/or legal guardian. Additionally, any medications must be accompanied by written and explicit instructions from said parent/guardian and may require physician authorization as well. In case of a medical emergency, I authorize permission to the physician selected by the Goal Program and its' director's to hospitalize and authorize treatment to include, but not restricted to, injection, anesthesia or

surgery and to secure proper treatment for the child I am registering. Every effort will be made by the Goal Program to immediately contact the parent/legal guardian and/or emergency contact persons I have listed prior to making such decisions.

Registration: By "agreeing" I understand and agree to make all payments specified in the application **Registration Form** (both Early Bird & non Early Bird) which I signed and submitted. When submitting a registration form **Four weeks fees are due at the time of submission of registration. I also agree to pay all balances due on or before the start of the Summer Program.** I understand that no refunds or adjustments will be made for absences including, but not limited to, illness or after **THERE ARE NO EXCEPTIONS!**

By "agreeing", I understand that part of the camping experience involves activities, programs and interactions that may be new to my child, and that they come with certain risks and uncertainties beyond what my child may be used to in dealing with at home. I am aware of these risks and I am assuming them on behalf of my child. I realize that no environment is risk free, and so I have instructed my child on the importance of abiding by the camp's rules and my child and I both agree that he or she is familiar will these rules and will obey them. **By "agreeing"**, I represent, understand and fully grant permission to **Goal Program** and it's directors to take my child on trips and for my child to participate in all activities including swimming. Photographs or recorded video of Goal Program activities and use of any photographs or videos containing my child or likeness of my child can be used in promotional material or advertising.

Bus Service Agreement

By "agreeing", I represent and understand that if I choose to enroll my child for bus transportation that morning pick up and evening drop off must be at the same location. Morning bus pick up and evening drop off times are determined solely by the transportation provider, based on area, number of campers in attendance and distance from the camp facility. Parents/Guardian will be notified of pick and drop location as early as possible, but no later than one week before the start of camp.

Beginning week 1, all buses arriving on time at their designated morning pickup location and will wait 2-3 minutes for my child and then depart for their next stop. Buses will not be returning to pick up campers if they miss their morning pickup bus time.
Campers can be suspended or removed from camp for not observing bus rules and regulations to include but not restricted to such as profanity, damage, disrespect for others, bigotry, inappropriate sexual or unsafe behavior.
***The Goal Program does not guarantee the accuracy or consistency of morning pick up or evening home drop off times at any point during the program.**
Behavior at Camp
By "agreeing", I represent and understand **The Goal Program** reserves the right to suspend and/or expel any camper. Behaviors such as profanity, disrespect for others, bigotry, damaging any property, inappropriate sexual or unsafe behavior are sufficient grounds for suspension or expulsion.
By "agreeing", I represent and understand that the information I have provided is true and accurate.
Full Name Of Camper ___________________________________

I Agree to the Terms & Conditions of the Bus Agreement.
Please Sign if Using Bus Service____

I Agree to the Terms & Conditions of the Parent Agreement
Please Sign Here: ____ Date: _____/_____/_____
Signature of Parent or Legal Guardian

Recurring Payment Authorization Form

Schedule your payments to be automatically deducted from your bank account, or charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged each billing period for the total amount due for that period. A receipt will be emailed to you and the charge will appear on your bank or credit card statement.

Please complete the information below:
Child/ren Names ______________________________

I ____________________________ authorize The Goal Program to charge/debit my account
(full name)

indicated below on the **Monday** of each week for payment of my Afterschool Service.

Total Due: _________ Payment Frequency:__________________

Start Date: __________________________ End Date: _____________________

Billing Address ____________________________ Phone# ________________________

City, State, Zip ____________________________ Email ________________________

Checking/ Savings Account

☐ Checking ☐ Savings

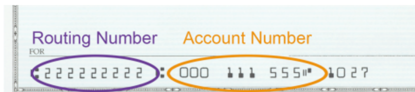
Name on Acct ____________________

Bank Name ____________________

Account Number ____________________

Bank Routing # ____________________

Bank City/State ____________________



Credit Card

☐ Visa ☐ MasterCard
☐ Amex ☐ Discover

Cardholder Name _________________________

Account Number _________________________

Exp. Date ____________

CVV (3 digit number on back of card) ______

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify The Goal Program in writing of any changes in my account information or termination of this authorization at least 7 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Nonsufficient Funds (NSF) I understand that The Goal Program will process the charge again within 2 business days, and agree to an additional $10 charge for each attempt returned NSF which will be added to the current bill. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute the scheduled transactions with my bank or credit card Company; provided the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _______________________________________ DATE ____________________

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE REGISTRATION

PHOTO OF CHILD (Optional)

Child's Full Name:

Does your child have any allergies? ☐ Yes ☐ No
If Yes, what is your child allergic to?

Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.

Child's Source of Medical Care/Primary Care Physician's Name:	Telephone Number:
Child's Source of Dental Care/Dentist's Name:	Telephone Number:
Name Of Medical Care Facility/Hospital:	Telephone Number:

Would you like information on Child Health Plus? ☐ Yes ☐ No

EMERGENCY DATA

RELATIONSHIP	CONTACT NAME	TELEPHONE NUMBER DURING CHILD CARE	OTHER TELEPHONE NUMBER (Check type)
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other

Provider/Day Care Facility Name and Address:

CHILD'S FULL NAME:	SEX: ☐ Male ☐ Female
CHILD'S HOME ADDRESS:	DATE OF BIRTH:
	HOME TELEPHONE NUMBER:
DATE OF ACCEPTANCE:	DATE OF DISCHARGE:
NAME OF PERSON APPLYING FOR CHILD: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ☐ Other _____	HOME TELEPHONE NUMBER:
	DAYTIME TELEPHONE NUMBER:
ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S):	

AGREEMENTS

I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.

I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision. ☐ Yes ☐ No

In case of accident or injury, I authorize any and all emergency medical, dental, and /or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child. ☐ Yes ☐ No

I have provided information on my child's special needs (Allergies, Diet, Disabilities, and /or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. ☐ Yes ☐ No

I agree to review and update this information whenever a change occurs and at least once every six months. ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE	DATE:

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

Medical Statement of Child in Childcare

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:

Immunizations required for entry into day care ☐ Yes ☐ No

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date	2nd Date	3rd Date	4th Date	5th Date
Polio (IPV or OPV)	1st Date	2nd Date	3rd Date	4th Date	
Haemophilus influenzae type B (Hib)	1st Date	2nd Date	3rd Date	4th Date **OR** 1st Date (if given on or after 15 months of age)	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date	2nd Date	3rd Date	4th Date	
Hepatitis B	1st Date	2nd Date	3rd Date		
Measles, Mumps and Rubella (MMR)	1st Date	2nd Date			
Varicella (also known as Chicken Pox)	1st Date	2nd Date			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Tests

Tuberculin Test Date: ___/___/______ Mantoux Results: ☐ Positive ☐ Negative __________ mm

TB Tests are at the physician's discretion.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: ___/___/______

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year ___/___/______ Result: ______________ mcg/dL ☐ Venous ☐ Capillary

2 years ___/___/______ Result: ______________ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

___/___/______ Result: ______________ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

ADDITIONAL INFORMATION ON REVERSE SIDE ➔

Medical Statement of Child in Childcare
(continued)

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam
Include special recommendations to Day Care Providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( )
Phone

Date

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.

CACFP
Child and Adult Care Food Program
New York State Department of Health

INCOME ELIGIBILITY FORM
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME: ______________________________

Print the name of the child(ren) enrolled in this child care center:

1. ____________________ 2. ____________________ 3. ____________________

DIRECTIONS:

Complete SECTION A if anyone in your household:

1. Receives Food Stamps
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. If any of the children enrolled in this child care center are foster children

Complete SECTION B if no one in your household receives Food Stamps, TANF, FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION A

Food Stamp Case Number ____________________

TANF Number ____________________

FDPIR Number ____________________

Names of Foster Children ____________________

____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature: ____________________

Date: ____________________

FOR SPONSOR USE ONLY

Sponsor Agreement Number ____________

Total Household Members ____________
(including foster children, if applicable)

Total Income $____________

Free _______ Reduced _______ Paid _______

Date Determined _____ / _____ / _____

Signature of Center Staff____________________

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

Name of Household Members	Monthly Gross Income
1. ____________________	$ ____________
2. ____________________	$ ____________
3. ____________________	$ ____________
4. ____________________	$ ____________
5. ____________________	$ ____________
6. ____________________	$ ____________

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature: ____________________

Print Name: ____________________

SS# XXX-XX-__ __ __ __ Date: __________

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the form. The Social Security Number is not required when you apply on behalf of a foster child or you list a Food Stamps, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the form does not have a Social Security Number. We will use your information to determine if the center is eligible for free or reduced-price meal reimbursement and for administration and enforcement of the Program.

INSTRUCTIONS FOR COMPLETING DOH-3688

Definition of Income

Income means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) Social Security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) unemployment compensation; (7) government civilian employee or military retirement, or pensions or veteran's payments; (8) private pensions or annuities; (9) alimony or child support payments; (10) regular contributions from persons not living in the household; (11) net royalties; (12) military benefits received in cash, such as housing allowance except if you are in the Military Housing Privatization Initiative; and (13) any other cash income.

Definition of Household

Household means *family* as defined in Section 226.2. *Family* means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

Instructions for Parents or Guardians:

Write in the name of the child care center in the space provided.

Print the name of each child in your household who attends this child care center.

Section A: If anyone in your household receives Food Stamps, Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the Food Stamp, TANF or FDPIR number (do not use your ACS or DSS child care subsidy number). Then sign and date the form and return it to the day care center.

Foster children: If your household includes a foster child who is in child care, write in the names of the foster children.

Section B: Complete this section if you did not complete Section A. Write in your name and the names of all other adults and children living in the household, including unrelated people, even if they do not have any income. Do not include the children in child care who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household, above. If any amount last month was more or less than the usual, write in that person's usual income.

The last four digits of the Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*. The form must be signed by an adult member of the household.

Instructions for Centers and Sponsors:

The *For Sponsor Use Only* section is to be completed, signed and dated by center or sponsor staff. The sponsor/center representative must review the income eligibility form and ensure that it is completed as indicated in the instructions above. Then indicate the following:

The Sponsor Agreement Number.

Total Household Members – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in child care and the number of foster children, if applicable.

Total Income – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the form must be categorized as *paid.*

Free, Reduced or Paid – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced** or **Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete forms (missing signatures, income information, or Food Stamp, TANF or FDPIR numbers) are categorized in the paid category.

The income eligibility form is valid until the last day of the month one calendar year from the date it is signed by the household member. For example, a form signed on May 12, 2011 is valid until May 31, 2012.

OCFS 6013 (2/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

TRANSPORTATION CONSENT FORM

Child Day Care Programs

Provider Name: The GOAL Program Facility ID Number: 647852, 647843, 647854

Program Name: The GOAL Program Facility ID Number: 694717, 630587 & 663565

This form may be used to meet the regulatory requirement to obtain written consent from the parent of a child for any transportation provided or arranged for by a caregiver, and to inform the parent when the person who is providing transportation changes. This form is not the Transportation Plan.

Parents whose children receive transportation services must receive, at the time of enrollment of their children, a copy of the program's transportation plan. If the plan is amended, parents must receive a copy of the amended plan prior to its start date.

It is recommended that a separate Transportation Consent Form be completed for each child.

☐ I have been informed of, and agree to, the transportation plan of the above child care program.

Transportation Plan is attached to this Transportation Consent Form (Yes / No) *circle one*

Date of Transportation Plan ____________________

☐ I give permission for my child *(name)* ____________________

to be transported by *(caregiver names and/or transportation contractor arranged for by the program)* ____________________

Parent Cell#:

Parent Work#:

At the following times *(check all that apply)*:

☐ Only as recorded on the posted transportation schedule for my child

☐ Other *(explain)*

____

____

____

By signing this form I am giving consent for the above described transportation services.

Parent Printed Name: ____________________

Parent Signature: **X** ____________________

Date ____________________

Waiver of Liability and Hold Harmless Agreement

In consideration for participating in any activities at **Greater Opportunities for Activities and Leadership Inc. (The Goal Program)**:

I hereby RELEASE, WAIVE, DISCHARGE, ANG AGREE TO HOLD HARMLESS The Goal Program, its Owners, Staff, or Volunteers from any and all liability, claims, demands, actions, third-party claims, and causes of action arising out of, or related to, any loss, damage, injury, including death, that may be sustained to me, or to any property belonging to me, whether caused by the negligence of RELEASEES, or otherwise, while participating in such activity, using The Goal Program's or its resources, or while in, on, or upon The Goal Program premises. I am fully aware of the risks and hazards connected with the program activities, field trips, pool trips, water park activities, sport activities, and tournament games. IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing Waiver of Liability and Hold Harmless Agreement.

………………………………………………………………………………… ………………………….
Printed Name of Parent/Guardian Date

………………………………………………………………………………… ………………………….
Signature of Parent/Guardian Date

Email:……………………………………………. Phone:……………………………………………..

GOAL SUMMER POOL/WATERPARK AND FIELD TRIP PERMISSION SLIP

The Goal Program will conduct trips during the Summer of 2016 to the following attractions:

POOL	DATES
• Willson's Woods Park & Swimming Pool East Lincoln Avenue, Mount Vernon, NY **OR** • Saxon Woods Park & Swimming Pool 1800 Mamaroneck Avenue, White Plains NY 10605	**JULY – 5, 12, 19 & 26TH 2016** **AUGUST – 2 & 9TH 2016** **TOTAL = 6 POOL TRIPS**
WATER PARK TRIPS	**DATES**
• The Funplex Play Ground & Water Park 3320-24 Rte 38, Mt Laurel, NJ 08054 (856) 273-9666	**JULY 7TH, 2016**
• Lake Compounce & Crocodile Cove 186 Enterprise Drive, Bristol, CT 06010 (860) 583-3300	**JULY 21ST, 2016**
FIELD TRIPS	**DATES**
• American Museum of Natural History Central Park W at 79th Street, New York, NY 10024 (212) 769-5100	**JUNE 30TH, 2016**
• Intrepid Sea, Air, and Space Museum 12th Avenue & 46th Street, Pier 86, New York, NY 10036 (212) 245-0072	**JULY 14TH, 2016**
• The Maritime Aquarium 10 N Water Street, Norwalk, CT 06854 (203) 852-0700	**AUGUST 4TH, 2016**
• New York Hall of Science 4701 111th Street, Flushing, NY (718) 699-0005	**AUGUST 11TH, 2016**

I ______________________________ GIVE PERMISSION FOR MY CHILD:

______________________________ TO ATTEND THE ABOVE MENTIONED **POOL/WATER PARK** AND **FIELD TRIPS**. I ALSO UNDERSTAND THAT IF I DO NOT WANT MY CHILD TO ATTEND THESE TRIPS; THEY WILL NOT BE ABLE TO ATTEND CAMP ON THAT DAY.

PARENT SIGNATURE: ________________________________ DATE: __________