FOR OFFICE USE ONLY: ___BC ___FF ___AP ___M ___ 1199 ___ DSS ___NEW

THE GOAL PROGRAM

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

APPLICATION

Date:_____

Child's Last Name: _____ First Name: _____ M.I. ___ DOB _____

Child Teachers Name: _____ Child Grade: ____ (MUST be entering Kindergarten): Age ____

Gender: M__ F__ School: _____

Mother's Full Name/Guardian_____

Address_____ apt # _____

City _____State_____ Zip _____

Home Phone _____ Cell: _____

Job Name & Address: _____ City _____ State _____

Zip _____ Work Phone: _____ Ext _____ Email: _____

Father's Full Name/Guardian_____

Address_____ Apt # _____

City _____ State _____ zip _____

Home Phone: _____ Cell: _____

Job Name & Address: _____ City _____State_____

Zip _____ Work Phone: _____ Ext _____ Email: _____

Emergency Contact List:

Name: _____Phone: _____Cell_____

Name: _____Phone: _____Cell_____

Name: _____Phone: _____Cell_____

Registration Information: Camp is 6 weeks. July 1 to August 9, 2024

(All children must REGISTER for a minimum of four weeks). ***ALL Fees are nonrefundable. Camp Hours are 8:00am-4:00pm. Extended Care is Provided 4:00pm-5:30pm***

All Summer Camp Fees Are Non-Refundable

Cost per week: $350 for 4 or 5 days with trips; $300 for 2 or 3 days; 2 or 3 days including Thursday trip is plus $25 per trip.

A. Registration fee: Returning Parents, $60, New Parents $125

B. 2 weeks fee minimum is due with the submittal of your child's application plus registration fee

C. All remaining fees must be paid in full on or before June 30.

D. Extended Day 4-5:30pm: $20 per day: (choose days) M__ T___W___ Th ___F___

Total Cost:

General Information/Special Needs

****

Does your child have Medical conditions? If yes please explain:_____
Is your child taking any medication? Explain: _____
Will your camper require medication during camp hours? **No Yes** If Yes, what **Type?** _____
If Yes, **Reason** for medication
_____
Does your child/camper have **allergies**? **No Yes** If Yes, please list below **what allergies and treatments for them**: _____
Any **Limits** for your camper? _____
Comments: _____

PLEASE READ AND SIGN:

Contract Agreement: A minimum of 2 weeks fees per registrant 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 activities. **Mask is required at all times**.
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, please make all checks payable to the 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 2 weeks fee per registrant plus registration fee is required. I also agree to pay all balances due by June 30. I understand that no refunds or adjustments will be made for absences including, but not limited to, illness or after. We cannot provide refunds due to Covid Illness 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 its 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.

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 Parent Agreement Please Sign Here:

_____ Date: _____/_____/_____

Signature of Parent or Legal Guardian

OCFS-LDSS-0792 (1/2005) FRONT

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:

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, and injury, 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:……...

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 _____ Camp Location:_____

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

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.

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.