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

Goal Summer Program

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

APPLICATION

(Please Print)

Pearls Hawthorne _____ School 32_____

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

A. Registration fee: ___$125 (Non-Refundable), Returning Parents, $60

B. Weekly fee: $260 (early bird special). After April 30, weekly fee $285

C. Week 1___Week 2___Week 3___Week 4 ____ Week 5 _____Week 6____ *Week 7_____

***Redmond Park- Week 7 – Field Week-** **located at 207 Cook Ave, Yonkers, NY 10701, this location has a covered Pavilion, restrooms, picnic area and large fields for games.**
***Pickup and drop off will be from Redmond Park.**

D. Transportation per week $80: Yes __ No__

E. Extended Day 4-5:30pm: $10 per day: (choose days) M__ T___W___ Th ___F___

Total Cost:

$125 + B. (minimum 4 weeks) $ _____+ C. $ _____+ D. $_____E.$_____= $_____

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 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, 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 **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 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.

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, disrespectful to 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

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:

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: _____

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

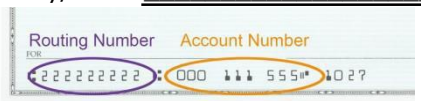
Name on Acct _____

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.

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:……...

GOAL SUMMER POOL/WATERPARK AND FIELD TRIP PERMISSION SLIP

The Goal Program will conduct trips during the <u>Summer of 2018</u> to the following attractions:

POOL	DATES
• Wilson's Woods Park & Swimming Pool East Lincoln Avenue, Mount Vernon, NY **OR** • Saxon Woods Park & Swimming Pool 1800 Mamaroneck Avenue, White Plains NY 10605 **OR** • Palisades Center Mall- Movie Trip 1000 Palisades Center Drive West Nyack, NY 10994	**JULY – 3, 10, 17, 24, 31st 2018** **AUGUST – 7 th 2018** **TOTAL = 6 POOL TRIPS** ***This a backup for Rain-date for Water/Pool trips**
WATER PARK TRIP	**DATES**
• Lake Compounce & Crocodile Cove 186 Enterprise Drive, Bristol, CT 06010 (860) 583-3300	**July 19H, 2018**
FIELD TRIPS	**DATES**
• Intrepid Sea, Air & Space Museum Pier 86 12th Ave & W46 Street New York, NY 10036 (212) 245-0072	**JULY 5TH, 2018**
• New York Hall of Science Museum 47-01 111th Street Corona, New York 11368 (718) 699-0005	**JULY 12TH, 2018**
• Medieval Times, Lyndhurst Castle 149 Polito Ave Lyndhurst, NJ 07071 (888) 935-6878	**JULY 26ST, 2018**
• Fishkill Farms 9 Fishkill Farm Road, Hopewell JCT, NY 12533 (845) 897-4377	**August 2 TH, 2018**

***Parents please note that Westchester Pools and some waterparks close during thunderstorms, We may move those trips around due to weather, as well as Substitute a Movie Trip at Palisades Mall ***

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 ATTEND CAMP ON THAT DAY.

PARENT SIGNATURE: _____ DATE: _____