

2016 SUMMER CAMP REGISTRATION FORM
ALL INFORMATION MUST BE FILLED OUT COMPLETELY AND MUST BE LEGIBLE

PROGRAM SITE (CIRCLE ONE): **BEATTY FEDDERSEN MARION FRANKLIN SULLIVANT GARDENS**

PARTICIPANT

Child's name _____ Male/Female (circle one) Current Grade _____

Birth date: ___/___/___ Age: _____ School _____ Teacher _____

Health Conditions (circle all the apply):

Speech Impairment Hearing Impairment Vision Impairment Asthma Diabetes
ADD ADHD ODD Bleeding/Clotting Disorders Convulsions Frequent Ear Infections Insect stings and hay fever
Allergy restrictions _____ Treatment for allergies _____ Medications _____

Activities to be encouraged or limited: _____ Other health information: _____
Other _____

**Please note: Medical information must be accurate. We are not to dispense medicine of any sort to participants.*

PARENT/GUARDIAN INFORMATION

Name of Parent(s) or Guardian(s) of child _____

Address _____ Zip _____ Home phone () _____

Primary number:() _____ Alternate number () _____ E-mail (Optional) _____

****Circle the phone number above you can be reached at during 9:00am-5:00pm****

Child resides primarily with (circle one): Mother Father Mother/Father Other: _____

EMERGENCY CONTACTS (OTHER THAN PARENTS)

NAME	Home Phone	Cell Phone	Work Phone	Relationship
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

THIS PROGRAM IS SUPPORTED BY THE CITY OF COLUMBUS, COMMUNITY DEVELOPMENT BLOCK GRANT. WE ARE REQUIRED TO REPORT THE FOLLOWING INFORMATION ABOUT THE FAMILIES THAT RECEIVE THIS SERVICE. ALL AREAS MUST BE FILLED IN.

Please check the categories your child is identified as (You can circle more than one) :

American Indian/Alaska Native American Indian/Alaskan Native and White Asian Asian and White
Black or African American Black/African American and White Native Hawaiian/Other Pacific Islander
White/Caucasian Other Continents: _____ (please explain)

Note: If you chose not to identify yourself please let the Site Director know.

Is household a female-headed household? Yes ___ No ___

Please circle the appropriate income based upon the number of members in your household.

PLEASE REFER TO THE ATTACHED INCOME SHEET

CAPITAL KIDS EMERGENCY MEDICAL AUTHORIZATION

(You must complete all sections of either Part 1 or Part 2 of this section. Do not complete both)

Part 1: Permission to transport child: In the event of an emergency, I _____ hereby give the Emergency Medical Service (EMS) permission to take my child to the following medical and dental facilities or to the nearest available source of help.. I understand that staff will give children basic first aid when necessary.

Parent/Guardian signature _____ Date _____
OR

Part 2: Refusal to give permission to transport child. I _____ **DO NOT** give permission to take my child to a medical or dental facility. I understand that staff will give participants basic first aid when necessary, but if an illness or injury requires emergency treatment, please do the following: _____

Parent/Guardian signature _____ Date _____

Does your child have health insurance coverage such as Medicaid, Healthy Start, or private insurer? Yes ___ No
Would you like to receive information about Healthy Start, a health insurance plan for children? Yes ___ No

INFORMATION/PHOTOGRAPHY RELEASE

The staff, the media, and programming partners with permission from the City of Columbus Recreation and Parks Department, may photograph or videotape my child for educational and public relations purposes.

Signature _____ Date _____

FIELD TRIP, ROUTINE AND ACTIVITY RELEASE

I give permission for my child to participate in all field trips, routine trips, and activities offered by the Capital Kids Program. These trips may include walks to parks, libraries, or other places close to the center. They are for educational and recreational purposes of the program. I understand while staff attempts to tell parents when they will leave for a trip, sometimes trips are spontaneous, and parents cannot be told in advance. The center will always know when the group left and when to be expected back. I also authorize the City of Columbus to do everything necessary to make sure of my child's health and safety in case of an emergency. I agree to not hold the City of Columbus, staff and sponsors of the program responsible for property damage or injury that results from my child's participation in this program.

Signature _____ Date _____

I also authorize the City of Columbus to do everything necessary to make sure of my child's health and safety in case of an emergency. I agree to not hold the City of Columbus, and the leaders and sponsors of the program, responsible for property damage or injury that results from my child's participation in this program.

Signature _____ Date _____

RECEIVED BY: _____ **Date:** _____
(Capital Kids Staff name)

Federal Register | Annual Update of the HHS Poverty Guidelines

Persons in family/household	Poverty guideline
1	\$11,770
2	15,930
3	20,090
4	24,250
5	28,410
6	32,570
7	36,730
8	40,890

For families/households with more than 8 persons, add \$4,160 for each additional person.

