Nantucket Community School

ENGAGING, STRENGTHENING & CONNECTING OUR COMMUNITY

ACKventure Day & Sports Camp
Registration Form - 2019

Participant's Full Name: _____

Parent/Guardian's Name: _____

Mailing Address: _____

Home Telephone #: _____ **Cell #:** _____

Email Address (REQUIRED): _____

Name of Camp	Camp Dates	Total Due
		$
		$
		$
		$
T-Shirt Size (ACKventure Day Camp Only) ☐ Youth Small ☐ Youth Medium ☐ Youth Large ☐Adult Small ☐Adult Medium ☐ Adult Large	One Time Registration Fee (Per Child Enrolled)	$45
	Total Due:	$

Payment Options

☐ Cash ☐ Check ☐ Master Card ☐ Visa ☐ Money Order ☐ Paid Online

Credit Card #: _____

Expiration Date: _____ / _____ **Security Code:** _____

Name on Credit Card: _____

Billing Address: _____

www.nantucketcommunityschool.org

EMERGENCY CONTACT FORM

Child's Name: _____ Age: _____

Date of Birth: _____ Grade in Fall: _____ School: _____

We are required to have the following information for EACH child enrolled in camp.

CONTACT INFORMATION

Primary Address: _____

Parent 1: _____ Day and/or Cell #: _____

Parent 2: _____ Day and/or Cell #: _____

Primary Contact: _____ Day and/or Cell #: _____

REQUIRED—Additional Emergency Contacts/Authorized Pick-Up Contacts - other than Parent

Name: _____ Day and/or Cell #: _____

Name: _____ Day and/or Cell #: _____

Preferred Language for Communication: _____

MEDICAL & GENERAL HEALTH

HEALTH CONDITIONS / ALLERGIES

Child's Physician: _____ Phone Number: _____

Child's Health Insurance Carrier: _____ Insurance Policy Number: _____

❒Surgery ❒Recent Injury ❒Recurrent/Chronic Illness ❒Fainting ❒Asthma/Wheezing

Please note additional concerns or details below: _____

_____

Is your child currently taking any medications? ❒YES ❒NO

Name of Medications: _____

I give permission for the designated camp staff member to administer the following:

❒Calamine Lotions ❒Sunscreen ❒Insect Repellent ❒Acetaminophen (Tylenol) ❒Benadryl ❒Ibuprofen (Advil) ❒Sudafed

❒All of the above ❒None of the above

Does your child carry the following? ❒INHALER ❒EPI-PEN **If Yes, can they administer themselves?** ❒YES ❒NO

Check the following that apply: ❒IEP ❒504 ❒Custody Agreement

EMERGENCY MEDICAL AUTHORIZATION

In the event a student is injured or becomes ill while participating in a program offered through the Nantucket Community School the team member in charge will contact the participant's parent, guardian and/or emergency contact. However, if the parent, guardian and/or emergency contact cannot be reached, or if in the judgment of the staff, the illness or injury requires immediate attention, the Nantucket Community School is authorized to obtain such medical assistance as the team member in charge may deem necessary or proper, including, but not limited to appropriate medical treatment at Nantucket Cottage Hospital. In order to provide this authorization, this completed Emergency Medical Authorization Form must be submitted and on file with Nantucket Community School. I/We, _____, the Parent(s)/legal guardian(s) of said child, _____, who is enrolled in the Nantucket Community School's program/class authorize the above child to be taken to Nantucket Cottage Hospital when the need for such treatment is immediate and efforts to contact me are unsuccessful. I acknowledge that I am responsible for all charges in connection with care and treatment rendered during this period.

Parent/Guardian Signature: _____ Date: _____

GENERAL INFORMATION

By signing this document, I give permission for my child enrolled in camp to:

- Be transported by Nantucket Community School to participate in all Nantucket Community School program activities and related field trips.
- Be photographed by NCS staff and NCS vendors for use in publication/marketing.
- To participate in swimming/aquatic activities (NCS will assess each child's skill level, per camp licensure).

Additionally, I give NCS permission to share my contact information with collaborating vendors.

To opt out of any of these conditions please email the NCS Business Office Manager: manchesterk@npsk.org

Parent/Guardian Signature: _____ Date: _____

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Drop-off and Pick up Policy

The following information is important for the safety and protection of your child. Please read this information carefully and sign below.

- I understand that my child will only be released to the authorized individuals I have listed on the Emergency Contact Form. Any changes to this form must be done in person and in writing with a signature from a legal guardian.
- I understand that a state-issued photo ID is required at pick-up and may be requested at any time from me or any person authorized to pick up my child.
- I understand that my child will not be released to any person who appears to be under the influence of drugs or alcohol.
- I understand that I am not to leave my child at Nantucket Community School or related program sites unless a Nantucket Community School staff member or volunteer is there to receive and supervise my child.
- I understand that it is my responsibility to sign-in my child each morning and sign-out my child before leaving each afternoon.
- I understand that my child will not be allowed to leave the program with an unauthorized person.
- I understand that Nantucket Community School is mandated to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation.

_____ _____ _____

Parent/Guardian Signature | Parent/Guardian Printed Name | Date

Hold Harmless Agreement & Consents

I, _____, the parent/ guardian of minor child, _____, voluntarily enroll said child in the Nantucket Community School program and with enrollment, voluntarily consent to the Nantucket Community School's policies and hereby give permission for my minor child to participate in the registered programs.

I, _____as the_____ parent/legal guardian of minor child listed above who is enrolled in the Nantucket Community School's program/class authorize that said child be taken to the Nantucket Cottage Hospital when the need for such treatment is immediate and efforts to contact me are unsuccessful. I acknowledge that I am responsible for all charges for treatment and subsequent care rendered during this period.

I,_____as the_____ parent/legal guardian of minor child listed above, understand and agree to save and hold the Town of Nantucket, the Nantucket Public Schools, the Nantucket Community School, its agents, servants and employees, harmless from any liability in any way for any occurrence in my voluntary enrollment of myself or my child in this activity which may result in bodily injury, property loss or damage, death or other damages to me or my family, heirs or assigns. In consideration of voluntarily participating and being allowed to enroll my child in this activity, I hereby personally assume all risks for injury in connection with this course/program/activity. I understand that I will be financially responsible for any damage my child may cause in 2019 on any property of the Nantucket Public Schools, Nantucket Community School or any satellite program locations. I understand that my child may also lose the privilege of participating in all current and/or future Nantucket Community School programs.

I further state that I am of lawful age and legally competent to sign this affirmation and release; that I understand the terms here in are contractual and not a mere recital; and that I have signed this document as my own free act. Furthermore, if registering for an activity that involves physical exertion, I state that I have consulted with a physician regarding my child's physical health. I affirm that my child is physically fit and I assume responsibility for the risk of injury to my child. I have fully informed myself of the contents of this affirmation and release by reading it before I signed it. By virtue of my signature below I attest that I have asked any and all questions and received satisfactory answers to any and all questions I may have had regarding this hold-harmless agreement.

_____ _____ _____

Parent/Guardian Signature | Parent/Guardian Printed Name | Date

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name _____ ☐ Male ☐ Female Date of Birth:_____
Medical History _____
_____

Pertinent Family History

Current Health Issues

Y	N	
☐	☐	Allergies: Please list: Medications _____ Food _____ Other _____
		History of Anaphylaxis to _____ Epi -Pen®: ☐ Yes ☐ No
☐	☐	Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)
☐	☐	Diabetes: ☐ Type I ☐ Type II
☐	☐	Seizure disorder: _____
☐	☐	Other (*Please specify)* _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:**_____

Hgt: _____(_____%) Wgt:_____(_____%) BMI: _____(_____%) BP: _____
(Check = Normal / If abnormal, please describe.)

☐ General _____	☐ Lungs _____	☐ Extremities _____
☐ Skin _____	☐ Heart _____	☐ Neurologic _____
☐ HEENT _____	☐ Abdomen _____	☐ Other _____
☐ Dental/Oral _____	☐ Genitalia _____	

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other_____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
TB Test Type: ☐ TST ☐ IGRA Date: _____ Result: ☐Positive ☐Negative ☐Indeterminate/Borderline
Referred for evaluation to: _____ Date:_____ ☐ Low risk (no TB test done)

This student has the following problems that may impact his/her educational experience:
☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations:_____

☐Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** _____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record**.

_____ _____
Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____
Group Practice Telephone

_____
Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 08/15/13*