TOWN OF FORESTBURGH YOUTH RECREATION
SUMMER YOUTH PROGRAM REGISTRATION FORM

Time: 9:00 a.m. to 2:30 p.m.

Parent/Legal Guardian:_____

Address:_____

Home Telephone:_____

Mother's Work #:_____ Cell:_____

Father's Work #:_____ Cell:_____

Emergency Contact:_____ Phone:_____

THE FOLLOWING PEOPLE HAVE MY/OUR PERMISSION TO PICK UP MY CHILD/CHILDREN AT ANY TIME WITHOUT A WRITTEN NOTE. **(NO OTHER PERSON WILL BE ALLOWED TO PICK UP YOUR CHILD/CHILDREN WITHOUT A WRITTEN SIGNED NOTE.)** PLEASE LIST ALL.

Name:_____ Phone:_____

Name:_____ Phone:_____

Name:_____ Phone:_____

CHILDREN ATTENDING

NAME	DOB	ENTERING GRADE
1.		
2.		
3.		
4.		

Does your child/children have any special talent? (i.e. singing, dancing, baton twirling, etc.)

New York State Department of Health requires a copy of the vaccination record(s) for all camp attendees. Please provide a copy when submitting this application. Thank you.

_____ _____
Parent/Legal Guardian Parent/Legal Guardian

This program is funded in part by a grant from the New York State Office of Children & Family Services through sponsorship by the Sullivan County Youth Bureau.

CATSKILL REGIONAL MEDICAL CENTER

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR TEMPORARILY SEPARATED FROM PARENT/GUARDIAN

I/We, the undersigned, custodial parent(s)/guardian(s) of_____, a minor, do hereby authorize **TOWN OF FORESTBURGH SUMMER CAMP/PROGRAM,** or any authorized representative thereof, as our agent(s) to act in my/our name, place and stead in any way in which I/we could do, if I/we were personally present, with respect to said minor, including, with limitation, giving consent to any diagnostic procedure or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of any licensed physician or surgeon on the staff of or engaged by Catskill Regional Medical Center, whether such diagnosis or treatment is rendered at the office of said physician or at Catskill Regional Medical Center.

With respect to consent to diagnostic procedures or medical care, it is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of my/our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his/her best judgment may be deemed advisable.

This authorization shall remain effective until **September 1,** unless sooner revoked in writing and delivered to said agent(s).

_____ _____
(Signature of custodial parent or guardian) (date)

_____ _____
(Signature of custodial parent or guardian) (date)

_____ _____
(Witness) (date)

Custodial Parent(s)/Guardian(s) Contact Information

Name:_____

Permanent Address:_____

Temporary Address:_____

Phone Numbers: Home:_____ Cell:_____

Insurance Carrier/Plan:_____ Policy I.D.#_____

Insurance Company Address & Phone #:_____

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.