

TOWN OF FORESTBURGH YOUTH RECREATION  
SUMMER YOUTH PROGRAM REGISTRATION FORM  
July 2nd – August 10, 2018

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.