

The New Kings Bay YM-YWHA Day Camp
3495 Nostrand Avenue, Brooklyn, New York 11229
Tel: 718-648-7703 Ext.223 ♦ Fax: 718-648-0758 ♦ E-Mail: dzeltser@kingsbayy.org

Kings Bay Y AFTER- CAMP

2010 AFTER-Camp Application

Camper's Name _____ Male ___ Female
 Date of Birth _____ Age _____ School _____ Grade in Sept. 2010 _____
 Home Address _____ Apt # _____ Zip _____
 Home Phone _____ Cell Phone _____
 Father's Name _____ Business Phone _____
 Business Name and Address _____
 Mother's Name _____ Business Phone _____
 Business Name and Address _____
 Emergency Name (Other than parent) _____ Phone _____

E-Mail Address _____

How did you hear about us? Friends Flyer TV Radio Internet

Special Requests:

Please list any allergies that your child has: _____

PLEASE CHECK APPROPRIATE AGE AND SESSION

	2 Weeks 8/23- 9/3	Week 1 8/23- 8/27	Week 2 8/30-9/3
After-Camp (8:30am -4:15pm)	<input type="checkbox"/> \$520	<input type="checkbox"/> \$280	<input type="checkbox"/> \$280
Early Drop off (7:45AM)	<input type="checkbox"/> \$40	<input type="checkbox"/> \$20	<input type="checkbox"/> \$20
Late Stay Option (4 PM-6:30PM)	<input type="checkbox"/> \$50	<input type="checkbox"/> \$25	<input type="checkbox"/> \$25
Combo (Early Drop Off & Late Stay)	<input type="checkbox"/> \$75	<input type="checkbox"/> \$50	<input type="checkbox"/> \$50

***Please note the late stay option is until 6pm on Friday.
 ** Transportation will not be available during the extended weeks.
 ** No scholarships are available during the extended two weeks.

Terms of Agreement

1. Full payment is due during the time of sign-up.
2. Make all checks or money orders payable to the "Kings Bay YM-YWHA".
3. Full payment is due prior to August 21, 2009.
4. After payment, no cancelations or refunds will be available.
5. A standard Department of Health Medical Form must be submitted to the camp by August 22, 2009. No camper may come to camp without a completed Medical form and an Emergency Authorization form.
6. The Kings Bay YM-YWHA is not responsible for any lost, stolen, or damaged property.
7. Due to unstable economic conditions, the Administration of the Kings Bay YM-YWHA reserves the right to add a minimal surcharge to any camp program.

8. If child misses camp due to sickness or family related issues, no make up or refunds may be issued.

I give permission to the Kings Bay YM-YWHA, Inc. to take photographs of me and/or my child to be shown in a video, brochure, advertisement, or internet display for purposes of promoting interest in the Kings Bay YM-YWHA. I release the Kings Bay YM-YWHA, Inc. from any claims resulting from the pictures taken on, before, or after the date of this communication.

I do hereby give permission for my child to participate in all camp activities and including off-ground activities, and authorize the Kings Bay YM-YWHA, Inc. to act as parent surrogate on my behalf. I realize that itineraries and/or programs are subject to change prior to and during the camp season. I do hereby give authority to the day camp and staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

I have carefully read the contract and other related information and agree to accept all terms.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

PARENT INFORMATION STATEMENT

Kings Bay Y After- Camp

(Name of Camp)

3495 Nostrand Avenue Brooklyn, NY 11229

(Address)

This camp is licensed by the New York City Department of Health and Mental Hygiene and is inspected twice yearly. We operate with a permit granted by The City of New York Department of Health and Mental Hygiene. The inspection reports are filed at the Bureau of Food Safety and Community Sanitation;
OFFICE OF WINDOW FALL PREVENTION AND DAY CAMPS
NEW YORK, NY 10007

FOR OFFICE USE

MEMBERSHIP FEE _____ DATE _____ RECEIPT # _____ AMT. PAID _____

FULL CAMP FEE _____ DATE _____ RECEIPT # _____ AMT. PAID _____

PARTIAL PAYMENTS

DATE _____ RECEIPT # _____ AMT. PAID _____

DATE _____ RECEIPT # _____ AMT. PAID _____

DATE _____ RECEIPT # _____ AMT. PAID _____

DATE _____ RECEIPT # _____ AMT. PAID _____

REMARKS:

OFFICE STAFF SIGNATURE _____