

**Park Shore Country Day Camp and School
Health Form 2011**

450 Deer Park Road, Dix Hills, NY 11746-5205
Phone # (631) 499-8580 * Fax # (631) 499-6917

The information on this form is to assist us in planning appropriate care. Any information updates should be provided to the office prior to your child's arrival to Park Shore. Please provide complete information.

Camper's Name _____
Last First Middle

Birth date _____ Age at camp _____ Present Grade (2010 - 2011) _____ Sex _____

Home address _____ Home phone _____
Street address City Zip

Father's Name _____ Home address _____
(if different from above)

Business Phone _____ Cell Phone _____

Mother's Name _____ Home address _____
(if different from above)

Business Phone _____ Cell Phone _____

Emergency Contact (Other than parents) Relationship Home/Work/Cell Phone

Allergies (List all known)

Describe reaction and management of the reaction.

Medication allergies (list)

Food allergies (list)

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

Restrictions (The following restrictions apply to this individual.)

Does not eat: ___ Red meat ___ Pork ___ Dairy Products ___ Poultry ___ Seafood ___ Eggs ___ Other (describe) _____

Explain any restrictions to activity (e.g. What accommodations or limitations are necessary?)

*IN THE EVENT THAT I OR MY CONTACTS CANNOT BE REACHED IN AN **EMERGENCY**, I HEREBY GIVE MY PERMISSION TO PARK SHORE, THE LOCAL AMBULANCE/FIRE DEPARTMENT, MY FAMILY PHYSICIAN, ANY LOCAL PHYSICIAN, OR THE NEAREST HOSPITAL TO ADMINISTER EMERGENCY TREATMENT AND CARE. I FURTHER GIVE MY PERMISSION FOR ALL PERTINENT HEALTH INFORMATION TO BE DUPLICATED AND RELEASED TO THE APPROPRIATE PERSONNEL FOR EMERGENCY CARE.*

Signature of Parent/Legal Guardian

Date

In order to better accommodate your child's needs; does your child receive special services in school or anywhere else? ___ Yes ___ No

If yes, please explain. _____



Dear Parents,

There may come a time when your child may require the administration of medication during the camp season and during camp hours. In the event that this occurs, our Professional Registered Nurses will dispense the medication **if and only if** the enclosed *Written Medication Consent Form* accompanies the medication. This form must be filled out in its entirety, completed by your physician and signed by you. According to the New York Department of Health, and the New York State Department of Education's Nurse Practice Act, the medicine, itself, must be supplied in its **original prescription bottle or manufacturer's bottle** (in the case of over-the-counter medication) with the child's name, the name of the medication, dosage instructions, physician's name, pharmacy's name and date. If you and your physician deem it necessary that your child carries his/her medication, then please call the camp for a *Self-Administration Medication Consent Form* and it will be mailed to you promptly.

If your child has been absent due to an illness or injury that required a visit to your health care provider, a note from your physician **must include the statement that your child may return to camp**, with specific activity restrictions, if applicable. In the health interest of all campers and staff at Park Shore and our vigilance in keeping all of Park Shore's campers healthy, we have enclosed guidelines for when you should keep your child home from camp. Please review this important and valuable information.

There may come a time when one of our Professional Registered Nurses or our Health Care Directors may contact you if your child was seen in the Health Center. The call may just be a means of communicating that your child was seen briefly or that your child is feeling ill and is unable to participate in the camp's activities or that your child needs to go home or it is the decision of one of our Registered Nurses or Health Care Directors that your child be seen by their physician or health care provider. Many of these calls are routine calls and it is felt that it is in the best interest of your child that communication is initiated. These calls and procedures are part of the comprehensive health care that is delivered at Park Shore Country Day Camp.

If you have any questions, please feel free to contact the Park Shore Health Center between the hours of 8:30 am and 4:30 pm at (631) 499-2070 beginning Monday, June 27th through Friday, August, 19th. Thank you.

Best wishes,

A handwritten signature in blue ink that reads "Monica Diamond-Caravella".

Monica Diamond-Caravella, MSN, RN, PMC
Health Care Director

A handwritten signature in blue ink that reads "Marilyn Byron".

Marilyn Byron, EMT-CC
Health Care Director

A handwritten signature in blue ink that reads "Bob & Chuck Budah".

Bob & Chuck Budah
Owners/Directors



450 Deer Park Road • Dix Hills, NY 11746
(631) 499-8580 • www.parkshoredaycamp.com



Park Shore Country Day Camp

450 Deer Park Road, Dix Hills, NY 11746-5205
 Phone # (631) 499-8580 *Fax # (631) 499-6917

Written Medication Consent Form

Child's First and Last Name:	Date of Birth:	Child's Known Allergies:
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Authorized prescriber to complete:

Licensed Authorized Prescriber's Name:		Licensed Authorized Prescriber's Telephone Number:	
Name of Medication (including strength if applicable):	Amount/Dosage to be Given:	Route of Administration:	
Date to be Discontinued or Length of Time in Days to be Given:	Time(s) to be Given:	Refrigeration Required: Yes <input type="radio"/> No <input type="radio"/>	
Reason for Taking Medication (unless confidential by law):			
Possible Side Effects:		What Action to Take if Side Effects are Noted:	
Special Instructions: (include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies, or any pre-existing conditions. Also describe situations when medication should not be administered)			
For PRN medication only: Identify the Symptoms That Will Necessitate Administration of Medication:			

Medication Consent/Authorization

I, _____ authorize Park Shore Country Day Camp's Licensed Registered Nurses to
 (Parent/Legal Guardian)
 administer the medication listed above to my child, _____ in Group _____.
 (Child's Name)

Required Signatures

_____ Licensed Authorized Prescriber's Name (please print)	_____ Licensed Authorized Prescriber's Signature	_____ Date
_____ Parent or Legal Guardian's Name (please print)	_____ Parent or Legal Guardian's Signature	_____ Date
_____ Name of Registered Nurse (please print) <i>(for office use only)</i>	_____ Registered Nurse Signature <i>(for office use only)</i>	_____ Date Received from Parent <i>(for office use only)</i>

When Is a Child Too Sick To Attend Camp? (as recommended by the American Academy of Pediatrics and adapted from Guidelines from the Child Care Council of Suffolk, Inc.)

GUIDELINES

1. Illness that results in a need for care that is greater than the staff can provide without compromising the health and safety of other children.
2. Fever defined by **100.4 degrees F or higher**. May return after **24 hours without fever**.
3. Diarrhea as defined as **one abnormally loose stool in the past 24 hours** or cannot be contained within toilet use. May return to camp **after diarrhea is resolved** and child is feeling well.
4. Effortful vomiting with or without fever after 6 pm the preceding evening. May return to camp when child has stopped vomiting for **at least 24 hours**.
5. Rash with fever or a rash that is possibly infectious (open, draining lesions). May return to camp when **determined noninfectious by physician**.
6. Severe sore throat or trouble swallowing with or without fever. Child may return to camp **after 24 hours after antibiotic treatment has been initiated and 24 hours without fever**.
7. Severe coughing, a croupy or whooping cough sound. Child may return when it is **determined noninfectious by physician**.
8. Constant runny nose.
9. Infected skin patches that are crusty, bright yellow, dry or gummy. May return to camp **24 hours after start of topical antibiotics (if prescribed) and determined noninfectious by physician**.
10. Severe itching of the body or scalp.
11. Purulent conjunctivitis ('pink eye') as evidenced by tears, redness of eyelid lining and irritation, followed by swelling and discharge of pus. Child may return to camp **after 24 hours after treatment has been initiated**.
12. Any contagious disease such as mononucleosis, chicken pox, etc.
13. If an antibiotic has been given for an ear infection, **wait 24 hours** before sending your child back to camp.
14. Mouth sores associated with drooling (in children unable to control oral secretions), fever, and poor appetite.

Keeping children home from camp when ill prevents the spread of disease.



EXPLORER RULES AND REGULATIONS

Registration in this program signifies the agreement to the following conditions:

THE FOLLOWING ARE PROHIBITED:

- Drugs, alcohol and tobacco
- Weapons of any type
- Physical violence
- Bullying in person or electronically via cell phone, texting, Facebook, etc.
- Harassment, rude or offensive language
- Travel without a camper buddy
- Theft, shoplifting or destruction of property
- Departure from an assigned activity, location or room without permission
- For the privacy of all our campers and staff members, pictures (via cell phone or camera) may only be taken under the supervision of a staff member.
- Use of cell phones during prohibited times.

Park Shore Country Day Camp reserves the right to search camper's personal belongings at any time. Campers who break any of these rules will be liable for any of the following consequences to be determined solely at the discretion of Park Shore Country Day Camp.

- Camper will be permanently removed for the remainder of the summer program.
- Camper will be returned home at the parent's expense.
- Camper will be suspended from camp for the duration of the next scheduled trip.

Park Shore Country Day Camp will not be responsible for any loss or damage to personal belongings. It is further understood that there will be no refunds of tuition.

I have read, fully understand, and accept the RULES & REGULATIONS set forth by the Park Shore Country Day Camp Explorer Program. Please return by 6/1/10.

Print Explorer's Name: _____

Explorer's Signature: _____

Parent's Signature: _____

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
<p>LUNCH & BOWLING 27</p> 	<p>FISHING 28</p> 	<p>ADVENTURELAND 29</p> 	<p>LIBERTY SCIENCE CENTER 30</p> 	<p>BEACH 1</p> 
<p>CAMP CLOSED 4</p> 	<p>BOOMERS 5</p> 	<p>CLUB GETAWAY 6</p> 	<p>ROLLER SKATING & LUNCH 8</p> 	<p>ROLLER SKATING & LUNCH 8</p> 
<p>GREAT ADVENTURE NJ 11</p> 	<p>ULTIMATE GAGA 12</p> 	<p>MOVIE DAY 13</p> 	<p>SPLISH SPLASH 14</p> 	<p>CULTURAL ARTS PLAYHOUSE 15</p> 
<p>BRONX ZOO 18</p> 	<p>HIGH ROPES ADVENTURE 19</p> 	<p>GREAT WOLF LODGE 20</p> 	<p>GREAT WOLF LODGE 21</p> 	<p>FAREWELL LUNCH & DAVE & BUSTERS 22</p> 

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
25 LASER TAG 	26  JUMP	27 BEACH 	28  GREAT ADVENTURE NJ	29 COUNTRY FAIR 
1  MCGUIRES COMEDY CLUB	2 CANOEING 	3 VILLA ROMA 	4 VILLA ROMA	5 ADVENTURELAND 
8 HURRICANE HARBOR 	9  LONG ISLAND IMAX AND LUNCH	10 MEDIEVAL TIMES 	11 METS GAME 	12 FISHING 
15  NEW ROC CITY	16 BAYVILLE ADVENTURE PARK 	17 SPLIT ROCK RESORT & INDOOR WATER PARK 	18 SPLIT ROCK RESORT & INDOOR WATER PARK	19 END OF SUMMER PARTY 

Over-The-Counter Medication Authorization

Child's First and Last Name:	Date of Birth:	Child's Age:
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Dear Parents/Guardians,

Occasionally while traveling, campers may require over-the-counter medications. The following over-the-counter medications will be carried by the travel Director in their first aid kit. Please review the list below with your child and circle the medications that you would like the travel staff to assist your child in taking.

PARENT/GUARDIAN AUTHORIZATION FOR STAFF ADMINISTRATION

MEDICATION	AILMENT
Advil	Headache/Pain/Fever
Motrin	Headache/Pain/Fever
Tylenol	Headache/Pain/Fever
Midol	Menstrual Pains
Benadryl	Allergy
Pepto Bismol	Upset Stomach
Dramamine	Motion Sickness

I give permission for Park Shore Country Day Camp travel staff member to assist my child in taking the medication I circled above in accordance to the proper dosage printed on the over-the-counter medication. Parents will be called by a staff member prior to assisting your child with this medication.

Parent/Guardian's Signature: _____

Print Name: _____

Park Shore Country Day Camp 450 Deer Park Road, Dix Hills, NY 11746-5205
Self-Administration Medication Consent Form

Child's First and Last Name:	Date of Birth:	Child's Known Allergies:
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Authorized prescriber to complete:

Licensed Authorized Prescriber's Name:		Licensed Authorized Prescriber's Telephone Number:
Name of Medication (including strength if applicable):	Amount/Dosage to be Given:	Route of Administration:
Date to be Discontinued or Length of Time in Days to be Given:	Time(s) to be Given:	Refrigeration Required: Yes <input type="radio"/> No <input type="radio"/>
Reason for Taking Medication (unless confidential by law):		
Possible Side Effects:	What Action to Take if Side Effects are Noted:	
Special Instructions: (include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies, or any pre-existing conditions. Also describe situations when medication should not be administered)		
For PRN medication only: Identify the Symptoms That Will Necessitate Administration of Medication:		

Medication Consent/Authorization

I, _____ request that my son/daughter _____ in the _____
 (Parent or Guardian's Name) (Child's Name) (Group)

self-administer the medication listed above.

I understand that he/she must bring the medication in its **original** prescription bottle or manufacturer's bottle with his/her name, the name of the medication and the dosage instructions. I understand that my son/daughter, and only my son/daughter will self-administer the medication as per his/her physician's orders. I attest that my son/daughter has demonstrated maturity, responsibility and capacity in self administering medication. I further attest that my son/daughter has demonstrated understanding of the indications and use of the prescribed medication (s) and that the medication (s) was prescribed solely for him/her.

Required Signatures

Licensed Authorized Prescriber's Name (please print)	Licensed Authorized Prescriber's Signature	Date
Parent or Legal Guardian's Name (please print)	Parent or Legal Guardian's Signature	Date
Camper's Name (please print)	(Camper's Signature)	Date

Park Shore Country Day Camp
450 Deer Park Road
Dix Hills, NY 11746
(631) 499-8580

Park Shore Travel Program
Emergency Contact Sheet
Explorer _____

(Please check one) Superteen _____

Camper's Name _____

Address _____

Town & Zip Code _____

Home Telephone # _____

Father's Business # _____

Father's Cell Phone # _____

Mother's Business # _____

Mother's Cell Phone # _____

List any dietary restrictions/medical conditions: _____

Emergency Contact: (Other than parents) Relationship Phone#

Name _____

Name _____

It is the hope that the authorization given here never need to be used. In an emergency situation, where the parent of the child cannot be contacted immediately, this form will be extremely important. The authorization will be used only where absolutely necessary and only after every attempt has been made to contact the parent.

I understand that in the event of an emergency, if I cannot be reached, I hereby give my permission to the physician or hospital selected by the camp administration to secure proper treatment for my child named above.

Date _____ Parent's/Guardian's Signature _____

PARTICIPANT REGISTRATION/WAIVER FORM

In consideration for being allowed to enter into the play area and/or participate in any party, event and/or all other programs at Ultimate GaGa I LLC ("Ultimate GaGa"), located in Syosset, NY, the undersigned, on his or her own behalf, and/or on behalf of the Participant(s) identified below, hereby acknowledges and agrees to the following conditions:

I represent that I am the parent or legal guardian of the Participant(s) named below, or I have obtained written or verbal permission from the parent/legal guardian of the Participant(s) named below to execute this Agreement on their behalf. I agree that the Participant(s) named below and I shall comply with all stated and customary terms, posted safety signs, rules, and verbal instructions as conditions for participation in any party and/or event and/or all other programs at Ultimate GaGa. In addition, if I observe any hazard during my/our participation, I will bring it to the immediate attention of the nearest Ultimate GaGa employee. Additionally, I take full responsibility for any and all damages to the facility and any of its contents arising from any Participant(s) refusal to follow all stated and customary terms, posted safety signs, rules and verbal instructions including any deliberate acts of damage and/or destruction.

I accept and am aware that there are inherent risks associated with physical activity and participation in Ultimate GaGa's programs and parties. Some of these risks cannot be eliminated regardless of the care taken to avoid injuries. Ultimate GaGa has facilities for and provides activities such as GaGa, Dodgeball, Kickball and other assorted kids games and classes. The specific risks vary from one activity to another but range from minor injuries such as scratches, bruises and sprains to more major injuries such as eye injuries or loss of sight, joint or back injuries, heart attacks and concussions as well as possible catastrophic injuries including paralysis and death.

I, for myself and the Participant(s) named below, and our respective heirs, assigns, administrators, personal representatives and, next of kin, hereby release and hold harmless Ultimate GaGa, their affiliates, officers, members, agents, employees and sponsoring agencies from and against any and all claims, injuries, liabilities or damages arising out of or related to our participation in any and all Ultimate GaGa programs, activities, parties, the use of the play area and other areas of the facility. I also agree to INDEMNIFY AND HOLD HARMLESS Ultimate GaGa from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities arising from the items referenced above as well as negligent rescue operations.

I have read and understand this Agreement fully and acknowledge that by executing it, I am waiving substantial rights, including my right to sue. I further acknowledge that I am signing this waiver under my own free will and hereby intend my signature below to represent a complete and unconditional release of all liability to the greatest extent permitted by law. This Agreement shall remain in effect unless and until it is withdrawn in writing by the parent or legal guardian of the Participant or the Participant themselves if over 18 years of age.

Participant Name: _____ **Date of Birth:** _____
Parent/Guardian/Participant

Signature: _____ **Date:** _____

Print Name: _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____

e-mail address: _____

Emergency Contact Telephone #: _____

Please check box:

- I do not wish to receive e-mail regarding party information
- I do not wish to receive e-mail regarding Ultimate GaGa promotions

Bayville Adventure Park

EXPRESS ASSUMPTION OF RISK, WAIVER, AGREEMENT NOT TO SUE, AND INDEMNITY AGREEMENT

READ THIS CAREFULLY – IT AFFECTS YOUR LEGAL RIGHTS

In return for the use of “Bradley Bay’s Rock Climbing Challenge and or Brittany Bay’s Jungle Tree Top Adventure, facilities and service (the “Facilities”) of the operator of Bayville Adventure park (as well as any other persons or entities related thereto) and/or its subsidiaries and affiliates (collectively Bayville Adventure Park), the undersigned for themselves or legal or acting guardian for themselves or the minor named below, their and minor’s heirs, assigns and legal representatives, hereby expressly agree to:

1. Release Bayville Adventure Park and all its successors, assigns, subsidiaries, operators, affiliates, officers, directors, employees, owners, agents, landlords, and creditors from any liability and agree not to sue them on account of, or in connection with, any claims, causes of action, injuries, damages, costs or expenses arising out of the below named use of or presence upon the facilities, including without limitation, those based upon death, bodily injury or property damage, whether or not caused by the negligence or activities of any person other than Bayville Adventure Park, including under theories of strict product liability or any other liability without fault;
2. Waive the protection afforded by the statute or law in any jurisdiction whose purpose, substance and or effect is to provide that a general release shall not extend to claims, material or otherwise, which the person or acting guardian giving the release does not know, or suspect to exist, at the time executing the release;
3. Acknowledge that the undersigned being fully aware of the risks and hazards inherent and associated with the anticipation in any events being conducted by Bayville Adventure Park, and acting for themselves and on behalf of the below named minor hereby voluntarily to enter the premises, use the facilities and to participate in the activities offered by Bayville Adventure Park, that the Guardian, acting for themselves and the minor hereby voluntarily assume risk of loss, damage or injury that may be sustained by themselves or the minor while involved in any activities at Bayville Adventure Park. In the event any accident which may require immediate medical/dental or any other emergency care, in which the guardian cannot be notified in a reasonable amount of time through the reasonable means, the undersigned hereby authorizes Bayville Adventure Park to take all necessary actions as it relates to immediate medical/dental care, transportation and or emergency medical services as Bayville Adventure Park representatives or a public or private emergency caregiver deems warranted in the course of care of the person or minor named below. The undersigned acknowledges and agrees that he/she shall be responsible for all fees and expenses of such care as they relate to this paragraph;
4. Acknowledge that in signing this agreement the guardian represents the following: (a) that the signer has read the foregoing agreement understands and signs voluntarily, (b) that the Guardian is of lawful age and is the parent or legal guardian of the below named minor, (c) that the signer has read, understands and will obey all the rules of the Bayville Adventure Park, (d) that the minor has the Guardian’s permission to participate in the activities and use the facilities at the Bayville Adventure Park, (e) that the person or minor does not have medical, emotional, or other conditions that may be effected by using the facilities and that will not impair the person or minors ability to understand instructions or to participate in the activities at the facilities without creating risk to the minor or other participants.

THE GUARDIAN READ THIS AGREEMENT, UNDERSTANDS THAT BY MAKING THIS AGREEMENT HE/SHE SURRENDERS VALUABLE RIGHT OF GUARDIAN AND ON BEHALF OF MINOR NAMED BELOW AND DOES SO FREELY AND VOLUNTARILY. THE GUARDIAN FURTHER CERTIFIES THAT HE/SHE IS AT LEAST 18 YEARS OF AGE AND LEGALLY COMPETENT TO SIGN THIS AGREEMENT. THE GUARDIAN FURTHER UNDERSTANDS THAT THE TERMS HEREIN ARE CONTRACTUAL AND NOT A MERE RECITAL. THAT HE/SHE HAS SIGNED THIS AGREEMENT AS HIS/HER OWN FREE ACT AND IF HE/SHE HAS ANY DOUBTS CONCERNING THE CONTENTS OF THIS AGREEMENT, HE/SHE MAY CONSULT AN ATTORNEY BEFORE SIGNING IT. ALL REFERENCES HERIN SHALL APPLY EQUALLY TO EACH GENDER.

_____ Guardian Signature	_____ Print Guardian Name	_____ Date
_____ Participants Signature	_____ Print Name	_____ D/O/B
_____ Mailing Address		_____ Phone



BIRTHDAY PARTY NAME _____

Release/Waiver

In consideration for being allowed to enter into the Jump facility and/or participate in any party and/or program at Jump of Ronkonkoma, N.Y., the undersigned, on his or her behalf and on the behalf of the participant(s), executors, heirs, successors and minors identified below, acknowledges, appreciates and agrees as follows:

1. The undersigned agrees to comply with the operational rules, posted signs and verbal instructions of the supervisors/employees of Jump as conditions for participation in any party and/or program at Jump. Also, if I discover any hazard during our participation, I will bring it to the attention of the nearest Jump employee.
2. The undersigned certifies that he or she is physically fit and may participate in the activities at Jump and have not been advised otherwise by a qualified medical person.
3. The undersigned acknowledges there are inherent risks associated with participation in Jump programs, parties and/or use of the play area and inflatable equipment.
4. The undersigned knowingly and fully assumes all risks known and unknown of danger, personal injury, disability and/or death, including those that may arise out of negligence of other participants or defective equipment.
5. The undersigned agrees to surrender and waive all claims or legal right to seek damages to person or property and furthermore agrees to hold harmless any authorized entity doing business as "Jump" and its officers, agents, employees, representatives and all affiliates.
6. The undersigned acknowledges that this release and waiver of liability form will be used and relied upon by Jump and it will govern the undersigned actions and rights.

Participants Name _____ Date of Birth _____

Participants Name _____ Date of Birth _____

Participants Name _____ Date of Birth _____

Address: _____ City, State, Zip _____

Email Address: _____ Emergency Phone Contact # _____

Parent/Guardian Acknowledgement

The undersigned parent and/ or guardian does hereby represent that he/she is, in fact, acting in such capacity and agrees to save and hold harmless and indemnify each and all of the parties referred to above of all liability, loss, cost, claim or damage whatsoever which may be imposed upon said parties because of any defect in or lack of such capacity to so act, and releases said parties on behalf of the minor and the parents or legal guardian.

Parent/Guardian _____ Date _____

Rules: Participants must remove shoes and wear socks. Participants must remove all jewelry and objects from their pockets. Obey employees at all times. No food or drinks on Inflatables. Participants must slide feet first and on their bottoms. No running/pushing/shoving/wrestling or rough play. No climbing or hanging. No Flips. Jump reserves the right to ask any guests who do not follow the rules to no longer participate.



The Long Island Home

Project C.A.R.E.
(Challenge Activities Ropes Experience)
2010/2011 – RELEASE FORM

Awareness of Program Policies

Project C.A.R.E. programs involve a variety of activities that often include warm-up games, group cooperative challenges, outdoor adventure low and high ropes course elements, and other physical activities. The level of participation is at all times up to the individual. We refer to this as "Challenge by Choice".

The staff will take reasonable precautions to ensure a safe activity. You will be given an overview of the program you are about to undertake, and you will be informed of specific safety rules and regulations that you will be expected to follow. Each individual participant assumes personal responsibility in confronting the real and perceived emotional and physical challenges.

I agree to cooperate with staff and follow their guidelines to ensure a safe & enjoyable activity.

Medical Screening, Waiver and Consent:

I understand that parts of the Project C.A.R.E. program may be physically or emotionally challenging. I affirm that my child or adolescent's health is good, and that he or she is not under a physician's care for any undisclosed condition that bears upon fitness to participate in Project C.A.R.E. activities. If I am 18 years or older, I affirm that my health is good and I am not under a physician's care for any undisclosed condition that bears upon fitness to participate in Project C.A.R.E. activities. I recognize the inherent risk of physical injury in any activity to my child, adolescent or myself. **I release and hold harmless The Long Island Home, d/b/a South Oaks Hospital, it's staff members and Board of Trustees from any and all liability for any injury to my child/adolescent or myself from participation in Project C.A.R.E. activities.**

Date: _____ Organization/Group/School _____

Applicant Information:

Name: _____

Address: _____

City, State, Zip _____

Telephone: Home #: _____ Business#: _____

Cell #: _____ Email: _____

Applicant's Signature _____

Parent/Guardian's Signature (if under 18 yrs.old): _____

Emergency Contact Name: _____ Emergency Contact #: _____

Please see other side for Photography Consent





The Long Island Home

Consent for Photography

I hereby grant the Long Island Home doing business as South Oaks Hospital permission to take photos and use the likeness of my son or daughter or myself (if 18 years or older) as a photograph, or other reproduction in any publications including website deemed appropriate to promote quality programming at The Long Island Home.

I understand this permission is binding upon my legal heirs and I will not be provided any payment or other consideration.

Applicant Name: _____

Applicant Signature: _____

Date: _____ Witnessed by: _____