**Township of Old Bridge**
**Parks and Recreation Department**

## Registration:

Participant:________________________________________Date of Birth:__________________Age:_______

Street:______________________________________________City:______________________State:_______

Zip Code:____________Home Phone:_______________WorkPhone:____________Emergency:____________

Parents or Guardian:____________________________________________________________________

Address/Phone:________________________________________________________________________

In case of emergency contact:____________________________________________Phone:________________

or contact:____________________________________________Phone:_________________

## Photo Release:

I do do not give permission for ______________________________ to be photographed for press use.
participant name

## Liability Release:

________________________________(Participant's Name) would like to participate in the Camp Robin recreation program of the Old Bridge Township Department of Parks and Recreation. The Old Bridge Township Parks and Recreation instructors / supervisors / leaders / aides / employees and / or volunteers agree to abide by all safety and procedural regulations required for the provision of safe programs and activities. I acknowledge the risks and potential for risks inherent in participation in Camp Robin Day Camp. However, I feel the possible benefits to myself / my son / my daughter / my ward are greater than the risk assumed. I hereby, for myself and for ________________________________(Participants name) waive and release all damages against Old Bridge Township and its representative personnel and release all damages against Old Bridge Township, for any and all injuries and / or losses I / my son / my daughter / my ward may sustain while participating in Camp Robin.

Date:_____________________ Signature:__________________________________
Participant, parent, or guardian

Date: ____________________

**Medical History**
**To be completed by family physician**

Name:______________________________DOB:_____/_____/_____Age:__________
Sex:__________ Height:__________ Weight:__________ Pulse:__________ B.P.:__________
Diagnosis:______________________________
Cause:______________________________
Date of Onset:____________________
Medications (Type, Purpose, Dose):______________________________
______________________________________________________________
If Downs Syndrome, Atlanto-Axial Subluxation? Yes_____ No______
Cervical X-Ray for Atlanto-Axial Subluxation: Positive_____ Negative_____ X-Ray date:_____/______/______
Tetanus Shot: Yes_____ No_____ Date_____/_____/_____

______________________________________________________________

Please indicate if the client has or had a history of the following secondary problems by checking yes or no. If **yes**, please include **complete** information pertaining to the problem.

| Problem | Yes | No | If yes, or history of, describe |
|---|---|---|---|
| Auditory Impairment | ___ | ___ | ______________________________ |
| Learning Disability | ___ | ___ | ______________________________ |
| Mental Impairment | ___ | ___ | ______________________________ |
| Psychological Impairment | ___ | ___ | ______________________________ |
| Speech Impairment | ___ | ___ | ______________________________ |
| Visual Impairment | ___ | ___ | ______________________________ |
| Allergies | ___ | ___ | ______________________________ |
| Cardiac | ___ | ___ | ______________________________ |
| Circulatory | ___ | ___ | ______________________________ |
| PVD | ___ | ___ | ______________________________ |
| | | | ______________________________ |
| Postural Hypotension | ___ | ___ | ______________________________ |
| | | | ______________________________ |
| Hemophilia | ___ | ___ | ______________________________ |
| Pulmonary | ___ | ___ | ______________________________ |
| Asthma/COPD | ___ | ___ | ______________________________ |
| Neurological | ___ | ___ | ______________________________ |
| Seizures | ___ | ___ | ______________________________ |
| Controlled | ___ | ___ | Type__________________________ |
| Last Seizure:_____/_____/_____ | | | |
| Hydrocephalus | ___ | ___ | ______________________________ |
| | | | ______________________________ |
| Shunt | ___ | ___ | # Revisions____________________ |
| Sensory Loss | ___ | ___ | ______________________________ |
| Pain | ___ | ___ | ______________________________ |
| Muscular | ___ | ___ | ______________________________ |
| Contractures | ___ | ___ | ______________________________ |

| Problem | Yes | No | If yes, or history of, describe |
|---|---|---|---|

Skeletal

| | | | |
|---|---|---|---|
| Spinal Column Injury | ___ | ___ | ______________________________ |
| Subluxing Joints | ___ | ___ | ______________________________ |
| Dislocating Joints | ___ | ___ | ______________________________ |
| Laminectomy/Fusion | ___ | ___ | ______________________________ |
| Scoliosis-Degree/Type/Brace/ Last X-Ray | ___ | ___ | ______________________________ |
| Kyphosis/Lordosis Degree/Type | ___ | ___ | ______________________________ |
| Spondylolisthesis | ___ | ___ | ______________________________ |
| Spinal Abnormality | ___ | ___ | ______________________________ |
| Osteoporosis | ___ | ___ | ______________________________ |
| Heterotrophis Ossification | ___ | ___ | ______________________________ |
| Joint Disease | ___ | ___ | ______________________________ |
| Cranial Defects | ___ | ___ | ______________________________ |
| Fractures | ___ | ___ | Location?________________Healed?__________ |
| Other_____________ | ___ | ___ | ______________________________ |

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## Medical History

Please indicate any medical problems not indicated above:

Please indicate special precautions:

## Mobility Status

Ambulatory? Yes_____ No_____

Can the student ambulate independently? Yes_____ No______

If no, describe:________________________________________________

## Prosthetics/Orthodontics

Type:________________________ Purpose:________________________

Type:________________________ Purpose:________________________

Please describe any other additional information that might help us to work with this student. Thank you for your time!

Physician's Signature:____________________________________Date:__________

Physician's Name (Please Print):____________________________________

Physician's Address:____________________________________________

Telephone Number:______-______-______

**Form to be completed by physician**

# Parental Evaluation

To enable or provide a positive summer experience for your child - please fully complete this form with detail, detail, detail!

Help us to know and understand your camper. The information you will provide us with, will help us insure that your camper has a positive, enjoyable experience. Do not **assume** anything!

Name of Parent/Guardian______________________________________________
Name of Camper________________________________ Age_______________

## General Health

1. Will camper take medication while at Camp?_____________________________
__________________________ Type______________________________________
If so, please complete medication form.

## Medication Form

Medication:_______________________
_________________________________
Dosage___________________________
_________________________________
Administration Schedule_______________
_________________________________
Expiration/Review Date________________
Restrictions_______________________
_________________________________

Medication:_______________________
_________________________________
Dosage___________________________
_________________________________
Administration Schedule_______________
_________________________________
Expiration/Review Date________________
Restrictions_______________________
_________________________________

Parent Signature_______________________________ Date_______________
Address_____________________________________ Telephone____________
Does camper take medication **at home**? Yes_____ No_____
Name of medication ____________________ When administered __________________
For what condition ____________________ Dosage ___________________________
2. Camper has or is subject to: (check)

______Asthma
______Diabetes
______Convulsions
______Heart Trouble
______Dizziness
______Sunburn
______Atlantoaxial Dislocation
______Glasses
______Contact Lenses
______Excessive Bleeding
______Heat Exhaustion
______Allergies or reaction to any plant, food, peanut products medicine, animal or insect bite
______Susceptible to Skin Irritations (poison ivy)

Explain, if necessary: ______________________________________________
________________________________________________________________

Has camper had any surgery or illnesses this past year. If so, please give details and dates:

______________________________________________________________________________

______________________________________________________________________________

3. Verbalization
   Is the camper able to express his/her needs? ______________________________________
   ____________________________________________________________________________
   Does he/she have a speech difficulty? _____________________________________________
4. Independence
   Is he/she able to dress self? ________ To what degree _______________________________
   ____________________________________________________________________________
   Is he/she able to feed self? ________ To care for his/her toilet needs? ____________________
5. General Information - For comments, please use other side of this sheet.
   Does the camper swim in deep water? Yes______ No______
   Does the camper seem to enjoy group activities? Yes______ No______
   Does he/she prefer outdoor activities? Yes______ No______
   Does he/she prefer indoor activities? Yes______ No______
   Does he/she indicate any particular fears? Yes______ No______

Height_____________________ Storms______________________ Animals_______________________
Transportation_______________ Water________________________ Others_________________________

In light of the camper's limitations are there any particular areas of development you feel should be strengthened during his/her attendance at camp?

______________________________________________________________________________

______________________________________________________________________________

Are there any specific recreational activities that camper really enjoys?

______________________________________________________________________________

______________________________________________________________________________

Is there any other information concerning the camper's social and emotional patterns that you feel would be helpful to the camp staff?

______________________________________________________________________________

______________________________________________________________________________

Are you or the camper currently in a day program using any behavior modification program?
Yes______ No______
If yes, please explain the program so we may continue it. ______________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

TOWNSHIP OF OLD BRIDGE
PARKS AND RECREATIONS
(732) 721-5600 Ext.4010

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required do to illness or injury during the process of receiving services, or while being on the property of the agency. I authorize Old Bridge Department of Parks and Recreation to:

1. Secure and retain medical treatment and transportaion if needed.
2. Release participants records upon request to the authorized individual or agency involved in the medical emergency treatment.

Participant's Name: ______________________Phone:________________________

Address:______________________________________________________________

In the event I can not be reached, Contact:_______________Phone:______________

Contact:_______________Phone:______________

Physicians's Name:_______________________Phone:_________________________

Preferred Medical Facility:_________________________________________________

Health Insurance Co.:_____________________Policy #_______________________

CONSENT PLAN
I do give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. This provision will only be invoked if the person below is unable to be reached.

Date:_______________Consent Signature:__________________________________
Participant, Parent or Guardian

Print Name: ______________________________Phone:_______________________

Address:______________________________________________________________

Sworn and subscribed before me this _______day of _____ **2023**

________________________
Signature or Notary

NON-CONSENT PLAN

I do not give my consent for emergency medical aid/treatment is required do to illness or injury during the process of receiving services, or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place :

Date:________Non-Consent Signature: ____________________________________
Participant/ Parent or Guardian

Print Name:_____________________________Phone_________________________

Address_______________________________________________________________

# Memo

**To:** Parents / Guardian :

**From:** Old Bridge Recreatiom

**Subject:** Ordering Extra Tee Shirt

**Date:** May 31, 2023

As part of your registration your child will be receiving a Camp R.O.B.I.N. tee- shirt. If you will like to purchase another tee shirt please fill in the form with the correct information. The cost of the extra tee- shirt will be $ 8.00. It is very important that your child wears the tee- shirt to camp every day. The tee- shirt is a form of identification when we are on trips.

**CAMP R.O.B.I.N. TEE-SHIRT FORM**

**Parent/Guardian Name :**

**Participants Name :**

**Please check off tee-shirt size and quantity.**

| SHIRT SIZE | QUANTITY |
|---|---|
| 6 - 8 | |
| 10 - 12 | |
| 14 - 16 | |

| ADULT SIZE | QUANTITY |
|---|---|
| Small | |
| Med. | |
| Large | |
| Ex-Large | |
| XX-Large | |

**Please make check payable to the Township of Old Bridge.**

# SUMMER REGISTRATION FORM

**PROGRAM: CAMP R.O.B.I.N.**

**NAME: ________________________ DATE OF BIRTH ____________ AGE ______**

**ADDRESS______________________________________________________________**

**CITY, STATE___________________________________________________________**

**HOME TELEPHONE____________________ CELL NUMBER_________________**

**T-SHIRT SIZE: (CHILD'S (6-8),(10-12),(14-16) OR ADULT, S,M,L, XL, XXL._________**

**PARENT / GUARDIAN NAME:___________________________________________**

**RELATIONSHIP:_______________________________________________________**

**CLASSIFICATION/**
**DISABLING CONDITION_______________________________________________**

**ALLERGIES__________________________________________________________**

**OTHER:_______________________________________________________________**

**E-MAIL:______________________________________________________________**