



# YMCA CAMP BERNIE

## NJEA Convention Vacation Camp

November 10th & 11th, 2011



Camper Name: \_\_\_\_\_ M/F: \_\_\_\_\_ Grade: \_\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

School District: \_\_\_\_\_

**Please use separate form for each child registered.**

*Registrations are due 7 business days prior to Vacation Camp on November 3rd. Registrations received after this date will be accepted based on availability and will be charged a \$10.00 late fee.*

\_\_\_\_\_ **NJEA Vacation Camp Nov. 10th** \$55, 9:00 am to 4:00 pm

\_\_\_\_\_ **NJEA Vacation Camp Nov. 11th** \$55, 9:00 am to 4:00 pm

\_\_\_\_\_ **Before Camp** \$15, 7:00 am to 9:00 am

\_\_\_\_\_ **After Camp** \$15, 4:00 pm to 6:00 pm

**Advantage School Program Participants:** \_\_\_\_\_ full time (5 days a week Before **or** After), \$55 waived  
 Please check all that apply \_\_\_\_\_ 2 days a week or more, \$45 Vacation Camp fee  
 \_\_\_\_\_ other

**Payment Information**

**Method of Payment**

\$ \_\_\_\_\_ Payment in Full

[  ] Check

\$ \_\_\_\_\_ Trading Post (\$5 per day recommended)

[  ] Visa [  ] MasterCard [  ] American Express

\$ \_\_\_\_\_ **Total**

Card # \_\_\_\_\_ Exp. \_\_\_\_\_

**Limited financial assistance is available.**

**For confidential financial assistance information contact Rose Price, Registrar at (908) 832-5315.**

**PERMISSION AND EMERGENCY INFORMATION**

My child \_\_\_\_\_ has permission and is physically and emotionally able to participate in an active Vacation camp(s) program(s) at YMCA Camp Bernie. In case of an emergency, I understand that every effort will be made to contact me. In the event that I cannot be reached, I hereby give my permission to the physician selected by YMCA Camp Bernie to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for my child. I give permission for photographs or videotape of my child to be used for YMCA promotional materials.

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency phone contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Medications (with instructions in original container) \_\_\_\_\_

Health problems/Histories/Allergies: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_