



SCHOOL DAYS OUT

2018-2019



Arts & Crafts



Swimming

Gym Games



GREENWOOD ATHLETIC
AND TENNIS CLUB

THE *Best* PART OF Your **KIDS'** Day![®]

PRE-REGISTRATION REQUIRED



SCHOOL DAYS OUT 2018-2019

The kids will have fun doing arts and crafts, playing gym games and swimming! The price is per day and includes lunch and snacks. Just bring your kids and their swimsuits.

AGES: 5-12 years

TIMES

Pre-camp	7:30-8:00am
Camp	8:00am-4:30pm
After-camp	4:30-6:00pm

CAMP COSTS (Pre-registration required)

Member	\$85
Non-Member	\$100
Pre-Camp	\$5
After-Camp	\$10
Special Snow Day	\$55 <i>Member and Non-Member</i>

Snow Day Camp: If school is canceled for a weather related issue Camp Greenwood will be open unless Greenwood Athletic and Tennis Club is closed. Please check website, GreenwoodATC.com for more details.

DATES

September	3, 21, 28
October	8-12, 15-19, 22, 23
November	6, 9, 19-21, 23
December	21, 24, 26-28, 31
January	2-4, 7, 18, 21
February	1, 6, 15, 18, 19
March	4, 7, 8, 18-22, 25-29
April	19, 29
May	3

Camp Greenwood Summer 2019

will begin Tuesday, May 28



Refunds and Make-up Days

Refunds are not granted except by written request in extenuating circumstances such as relocation or hospitalization. Once camp begins, we do not allow make-up days or refunds for any absences.



SCHOOL DAYS OUT | REGISTRATION FORM

Camper: _____

Age _____ Birthday _____ Gender _____ Grade _____

Member Non-Member

Parent Name #1 _____

Address _____

City _____ State _____ Zip Code _____

Email _____

Cell number _____ Home number _____

Parent Name #2 _____

Address _____

City _____ State _____ Zip Code _____

Email _____

Cell number _____ Home number _____

CAMP WEEK CHOICES *(Circle all your choices)*

MONTH	DATES
September	3, 21, 28
October	8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23
November	6, 9, 19, 20, 21, 23
December	21, 24, 26, 27, 28, 31
January	2, 3, 4, 7, 18, 21
February	1, 6, 15, 18, 19
March	4, 7, 8, 18, 19, 20, 21, 22, 25, 26, 27, 28, 29
April	19, 29
May	3

PAYMENT OPTIONS: Select method

(See General Information for pricing)

House Charge Check Cash

Credit Card

Credit Card Type _____

Card Number _____

Expiration Date _____

CVC _____ Zip _____

Signature _____

Non-members must provide a credit card number for our files, even when paying by cash or check.

Terms and Conditions:

_____/I/We request that my child be admitted to Camp Greenwood. I understand that my deposit is non-refundable. Remaining balance refunds are not granted except by written request in extenuating circumstances such as relocation or hospitalization. I agree to assume full risk and to waive, relinquish and release all claims I and/or the participant may have against, indemnify, hold harmless and defend Greenwood Athletic Club Metropolitan District and JAG Management Group, LLC. This includes as well its officers, agents, all personal medical insurances and that as a participant must cover all medical costs incurred. I also understand that every precaution is taken to protect the safety of each participant. I agree to emergency treatment by a physician or hospital in the event that I or the emergency contact can not be reached.

_____/I/We have read this release and understand all its terms and hereby execute it voluntarily with full knowledge and understanding of its significance.

Parent/Guardian Signature: _____ **Date:** _____

SCHOOL DAYS OUT | MEDICAL INFORMATION FORM

MUST BE COMPLETED!

Camper: _____ **Birthday** _____

IN THE EVENT OF AN EMERGENCY, CONTACT THE FOLLOWING:

Parent/guardian 1 _____

Employer _____

Address _____

City _____ State _____ Zip Code _____

Phone number _____ Email _____

Cell number _____ Work number _____

Parent/guardian 2 _____

Employer _____

Address _____

City _____ State _____ Zip Code _____

Phone number _____ Email _____

Cell number _____ Work number _____

PERSON OTHER THAN PARENT/GUARDIAN WHO IS AUTHORIZED TO APPROVE EMERGENCY MEDICAL TREATMENT:

Emergency Contact 1 _____

Employer _____

Address _____

City _____ State _____ Zip Code _____

Phone number _____ Email _____

Cell number _____ Work number _____

Emergency Contact 2 _____

Employer _____

Address _____

City _____ State _____ Zip Code _____

Phone number _____ Email _____

Cell number _____ Work number _____

In the event that reasonable attempts to contact parents/guardians mentioned above or other person(s) named above, full consent is given to emergency medical or hospital services that may be rendered by an accredited hospital or by an appointed physician(s), in the event that the administration of any treatment is deemed necessary by a duly licensed physician or medical practitioner.

SPECIFIC MEDICAL INFORMATION

List any communicable diseases, serious illnesses and/or surgeries which your child(ren) has had: _____

List any known drug allergies and/or drug reactions which your child(ren) has: _____

Describe any special diets your child(ren) must follow: _____

List any know food allergies: _____

List any prescriptive and/or non-prescriptive medications which your child(ren) must take:

MEDICATION	Dosage	Frequency	Prescribing Physician

Name and phone number of child's preferred medical personnel:

	Physician	Dentist	Preferred Hospital
Name			
Address			
Phone			

MEDICAL EMERGENCY CONSENT

____ I/We, being the parent(s)/guardian(s) of the above mentioned, give consent for emergency medical and/or surgical treatment in a licensed medical facility and by a licensed physician should my child(ren)'s condition require it in my absence. I/We understand that in such a case, reasonable attempts would first be made to contact us with time and conditions permitting. As long as the medical and/or surgical treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved. I/We impose no specific prohibitions regarding treatment unless stated here:

My son/daughter has the following medical condition(s) that may require emergency care including allergies and/or drug allergies:

____ I/We confirm to Greenwood Athletic and Tennis Club that my child(ren) is in good health and that his/her participation does not pose a hazard to his/her health or that of other participating campers.

____ I/We have read this release and understand all its terms and hereby execute it voluntarily with full knowledge and understanding of its significance.

Parent/Guardian Signature: _____ **Date:** _____



SCHOOL DAYS OUT | ACTIVITY INFORMATION FORM

Camper: _____ **Birthday** _____

Sunscreen Consent:

I/We, being the parent(s)/guardian(s) of the above mentioned, ___ give consent ___ do not give consent, for the use of Body Eclipse SPF 30+ to be applied to my child(ren) in the event their sunscreen is left at home.

Video Consent:

I/We, being the parent(s)/guardian(s) of the above mentioned, ___ give consent ___ do not give consent, for the viewing of age appropriate, "G" and "PG" rated videos in the event of inclement weather.

Photo Release Consent:

I/We, being the parent(s)/guardian(s) of the above mentioned, hereby consent that photographs taken by Greenwood Athletic and Tennis Club may be used by GATC for GATC promotional materials, including the GATC website. I understand that these photos will be used only for promotional purposes, and will not be given to other parties for any purpose other than to promote the club. I may also request that GATC cease from using any particular photo in future materials or promotions, by providing written notification to the GATC General Manager or Director of Marketing. Materials that are already in existence or production at the time I provide such written notice may continue to be used until supplies are exhausted. GATC includes these photos for purposes of marketing the club, in order to showcase the club and allow members and non-members to see the variety of services and activities available at the club.

___ I/We have read this release and understand all its terms and hereby execute it voluntarily with full knowledge and understanding of its significance.

Parent/Guardian Signature:

Date: _____



Child Release Consent: Children will only be released to parents or guardians listed on this form and individuals whose names appear below. All individuals must present a form of identification when picking up children from the program.

1) **Name** _____ *Relationship* _____ *Phone* _____

2) **Name** _____ *Relationship* _____ *Phone* _____

3) **Name** _____ *Relationship* _____ *Phone* _____

4) **Name** _____ *Relationship* _____ *Phone* _____

___ I/We have read this release and understand all its terms and hereby execute it voluntarily with full knowledge and understanding of its significance.

Parent/Guardian Signature: _____

Date: _____

CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com



COLORADO
Department of Public
Health & Environment

Colorado law requires this form to be completed by a school health authority or health care provider for each immunized student attending Colorado schools.

6 CCR 1009-2 The Infant Immunization Program and Immunization of Students Attending School: Schools shall have on file an official immunization record for every student enrolled.

Name: _____

Date of birth: _____

Parent/guardian: _____

Required vaccines

Each immunization date MM/DD/YY

Titer date

Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
DT Diphtheria, Tetanus (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib Haemophilus influenzae type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella date of disease	
Varicella positive screen date	

Recommended vaccines

Each immunization date MM/DD/YY

HPV Human Papillomavirus						
Rota Rotavirus						
MCV4/MPSV4 Meningococcal						
Men B Meningococcal						
Hep A Hepatitis A						
Flu Influenza						
Other						

Optional review signature by the school health authority or health care provider

I have reviewed this immunization record

Signature: _____

Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN/ADULT STUDENT

I authorize my/my student's school to share my/my student's immunization records with state/local public health and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Signature: _____

Date: _____