

****Most recent physical form, immunization records, copy of health insurance card, field trip release form, camp release form and credit card on file are required before the start of camp.**

REGISTRATION 2020



Camper ID: _____

Please fill out one registration per child:

Child's Name: _____

Date of Birth: _____ Grade Entering: _____ Sex: M F

Names of Sibling's In Program: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent's Name(s): _____ / _____

Spa 23 Member # _____

Cell Phone: _____ / _____

Work Phone: _____ / _____

Home Phone: _____ / _____

Parents' Emails: _____ / _____

Camper Email: _____

Emergency Contact (other than parent): _____

Emergency Phone: _____

Alternate Emergency Contact: _____

Alternate Emergency Phone: _____

Please list any allergies, special circumstances or restrictions we should be aware of concerning your child:* _____

*** Please be aware that we do not dispense medication to campers.**

By signing below I agree that my child has permission to engage in all camp activities, unless specifically noted on the Medical Form. In the event of an emergency I give consent to Spa 23 staff to act accordingly until I can be contacted. In the event that I cannot be contacted in an emergency, I hereby give permission to the Spa 23 Management to secure and administer treatment, including hospitalization for my child. Permission is granted for the Spa 23 staff to walk my child to and from Spa 23 and PV Park and to take my child on any trips as part of the camp program. I hereby give Spa 23 permission to photograph my child and use the photographs for marketing and promotion without any compensation. I understand that Spa 23 reserves the right to suspend or dismiss any camper if his or her conduct is detrimental to the well being of the camp or any other campers. There are no credits or refunds for suspensions, dismissals, or cancellations .

***By signing below I understand my child will not be admitted to CAMP Spa 23 until I have submitted the CAMP Spa 23 Health Form and copy of my Insurance Card.**

Print Parent/Guardian Name: _____

Signature: _____ Date: _____

Camper ID: _____ Child's Name: _____ Grade: _____

Choose the weeks your camper will attend:

- ____ Week 1 : June 22-26
- ____ Week 2: June 29– July 3
- ____ Week 3: July 6-10
- ____ Week 4: July 13-17
- ____ Week 5: July 20-24
- ____ Week 6: July 27-31
- ____ Week 7: August 3-7
- ____ Week 8: August 10-14
- ____ Week 9: August 17-21
- ____ Week 10: August 24-28

There is a \$39 charge for week changes.

Member:

of weeks _____ X \$199 =

Guest:

of weeks _____ X \$228 =

Pre-K:

of weeks _____ x \$39 =

Family Processing Fee:

____ \$29 Member

____ \$49 Non-Member

Paid by sibling (name): _____

Camper #: _____

TOTAL A = \$

Will your child be needing:

Before Care: 1 2 3 4 5 6 7 8 9 10

After Care: 1 2 3 4 5 6 7 8 9 10

Before Care #of weeks _____ X \$29 =

After Care #of weeks _____ X \$29 =

Hot Breakfast: 1 2 3 4 5 6 7 8 9 10

Breakfast Package # of weeks _____ X \$25 =

Daily M T W Th F # of days _____ X \$5.50 =

Lunch Package: 1 2 3 4 5 6 7 8 9 10

of weeks _____ X \$39 =

Daily M T W Th F # of days _____ X \$8 =

T-Shirt Size: YXS YS YM YL AS AM AL AXL

Extra T-Shirt: _____ X \$12 =

Camp Hat: _____ X \$15 =

Camp Bag: _____ X \$10 =

Camp Bottle: _____ X \$5 =

Bonus Programs: (See Flyer) # of weeks _____ X \$29 =

Math Refresher: 2 3 4 5 6 7 8 9

Kickboxing: 2 3 4 5 6 7 8 9

Drawing Club: 2 3 4 5 6 7 8 9

FunFit Relay: 2 3 4 5 6 7 8 9

Dance: 2 3 4 5 6 7 8 9

Yoga: 2 3 4 5 6 7 8 9

Swim Lesson: 1 2 3 4 5 6 7 8 9 10

of weeks _____ X \$69 =

Field Trip: 1 3 5 8 10

Full Day Trip: 2 4 6 7 9

Field Trips # of weeks _____ X \$29* =

Water Park _____ X \$59* =

Birthday Celebration:

Date of celebration: _____ X \$49 =

Turning what age? _____

TOTAL B \$

TOTAL A + B =

Additionally I authorize Spa 23 to charge my credit card on file in lieu of presenting it for any services received, at my request: Initial: _____

There are no credits or refunds for suspensions, dismissals, or cancellations .

Check # _____ Visa__ MC__ Amex__ Disc__ Card Number _____ Exp _____

Signature _____ Date _____

Spa 23 Staff Signature _____

Drop in Registration

2020



Camper ID: _____

Please fill out one registration per child:

Child's Name: _____ Sex: M F

Date of Birth: _____ Grade Entering: _____

Names of Sibling's In Program: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent's Name(s): _____ Member of Spa 23: Y N

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Parent's Email: _____

Emergency Contact: _____ Relation: _____

Emergency Phone: _____

Any special circumstances or restrictions we should be aware of concerning your child:

By signing below I agree that my child has permission to engage in all camp activities, unless specifically noted on the medical form. In the event of an emergency I give consent to authorize Spa 23 staff to act accordingly until I can be contacted. In the event I cannot be contacted in an emergency, I hereby give permission to the Spa 23 Management to secure and administer treatment, including hospitalization for my child. Permission is granted for the Spa 23 staff to take my child on any trips as part of the camp program. I understand Spa 23 reserves the right to suspend or dismiss any camper if his or her conduct is detrimental to the wellbeing of the camp or any other campers. There are no credits or refunds for suspensions, dismissals, or cancellations from camp.

***By signing below I understand my child will not be admitted to Camp Spa 23 if I do not have a yearly up-dated Health/Immunization record submitted by my first day of camp.**

Print Parent/Guardian Name: _____

Signature: _____ Date: _____

Choose the weeks your camper will attend:

- | | |
|------------------------------|------------|
| _____ Week 1 : June 22-26 | M T W TH F |
| _____ Week 2: June 29-July 3 | M T W TH F |
| _____ Week 3: July 6-10 | M T W TH F |
| _____ Week 4: July 13-17 | M T W TH F |
| _____ Week 5: July 20-24 | M T W TH F |
| _____ Week 6: July 27-31 | M T W TH F |
| _____ Week 7: Aug 3-7 | M T W TH F |
| _____ Week 8: August 10-14 | M T W TH F |
| _____ Week 9: August 17-21 | M T W TH F |
| _____ Week 10: August 24-28 | M T W TH F |

Member	Non-Member
# of days _____ x \$49 =	# of days _____ x \$59 =
4 Year Old Child _____ x \$59 =	4 Year Old Child _____ x \$69 =
Teen Camper _____ x \$49 =	Teen Camper _____ x \$59 =
Processing fee: (one time fee per family.)	
\$29 member _____	\$49 nonmember =

Before **or** After care: # _____ x \$7 =
M T W TH F

Before **AND** After care: # _____ x \$14 =
M T W TH F

Lunch Package: # _____ x \$8 =
M T W TH F

Breakfast Package: # _____ x \$5 =

Camp t-shirt must be worn every day of camp

T-Shirt Size: YXS YS YM YL XS S M L XL

Extra T-Shirt: # _____ x \$12 =

Camp Hat: _____ x \$15 =

Camp Bag: _____ x \$10 =

Camp Logo Water Bottle : _____ x \$5=

Field Trips: # _____ X\$29

Full Day Trips: # _____ X\$59

1: Bowling

2: Wild West City

3: Movies

4: Action Water Park

5: Dave and Busters

6: Turtle Back Zoo

8: Color Me Mine

7: Branchburg Sports Complex

10: Sky Zone

9: Fun Plex

\$ _____
\$ _____
\$ _____
\$ _____
\$ _____
\$ _____
\$ _____
\$ _____
\$ _____
\$ _____
\$ _____
\$ _____

\$ _____
\$ _____

Total: \$ _____	
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Check # _____	Card Type: Visa__ MC__ Amex__ Disc__
Card Number _____	Exp _____
Signature _____	Date _____
Spa 23 Staff Signature _____	



Field Trip Release Form

Camper Name(s): _____

Phone number(s): _____

I authorize the above camper(s) to attend Spa 23's Field Trips. I understand the nature of the activity in which my son/daughter will be participating and that he/she is expected to abide by all regulations during the course of the activity. I hereby give my permission for him/her to participate in All Spa 23 field trips that he/she is registered.

Date: _____

Signature of Parent/Guardian _____

IMPORTANT MEDICAL INFORMATION THE SUPERVISOR SHOULD KNOW:



CAMPER HEALTH FORM

Please return fully completed form prior to first day of camp

381 Rt. 23 Pompton Plains, NJ • (973) 839-8823 office • (973) 839-7563 fax

Each camper MUST have a fully completed medical form for the CURRENT CAMP YEAR or will not be admitted to camp.

Licensed Physician's Name: _____

Address _____

Phone () _____ Fax () _____

I hereby give my permission to release any pertinent medical information from any medical records to the staff of Spa 23. All Information will be kept confidential.
 Authorized Signature: _____
 Relationship: _____ date: _____

Camper's Name _____

Birth Date _____

To be completed by Physician:

I examined this individual on _____. (exam must be within 12 months of camp attendance.)

BP _____ Weight _____ Height _____ In my opinion, the above camper __ is __ is not able to participate in an active camp program. The camper is under the care of a physician for the following condition(s): _____

IMMUNIZATIONS (Please indicate month/year)

DPT						
TD						
MMR						
HiB						
Hepatitis B						
Varicella (chicken Pox)						
Polio						

Has the camper had any of the following:

___ Hepatitis C ___ Other ___
 ___ Measles ___ Chicken Pox ___ Mumps
 German Measles ___ Hepatitis A ___ Hepatitis B

Allergies: ___ None ___ Yes (indicate below)
 ___ Asthma ___ Hay Fever ___ Penicillin
 ___ Dairy ___ Soy ___ Wheat
 ___ Peanuts ___ Tree Nuts ___ Poison Ivy
 ___ Insect Stings ___ Bee Stings
 ___ Other _____

TB Mantoux Test: Date of Last Test: _____ Result: ___ Positive ___ Negative

Describe any current physical, mental or psychological conditions requiring medication, treatment or special restrictions or conditions while at camp.

Describe any camp activities from which camper is exempted.

Describe any dietary restrictions.

List all known allergies.

Date of completion of this form: _____ Completed by _____

Please FAX to 973-839-7563
 or mail to: 381 Route 23 Pompton Plains, NJ 07444

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name (Last) _____ (First) _____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____ / ____ / ____
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier _____	
Parent/Guardian Name _____		Home Telephone Number _____	Work Telephone/Cell Phone Number _____
Parent/Guardian Name _____		Home Telephone Number _____	Work Telephone/Cell Phone Number _____
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.			
Signature/Date _____		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination: _____	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormalities Noted: 	Weight (must be taken within 30 days for WIC) _____
	Height (must be taken within 30 days for WIC) _____
	Head Circumference (if <2 Years) _____
	Blood Pressure (if ≥3 Years) _____

IMMUNIZATIONS

- Immunization Record Attached
 Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print) _____

Signature/Date _____

Activity and Program Guest Registration

(Please Print)

Guest of _____

Greeted by _____

Name _____ Main Phone _____

E-mail _____

Street _____

City _____ State _____ Zip Code _____

Release of Liability, Disclosure of Risk and Physician Recommendation Agreement for Spa 23 Fitness and Lifestyle

1. In consideration of being allowed to participate in activities and programs of Spa 23 Fitness and Lifestyle hereinafter "Spa 23" and to use its facilities, equipment, and machinery in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge Spa 23 and its officers, agents, employees, representatives, executors, and all others from any and all responsibilities or liability for injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above mentioned facilities or arising out of my participation in any activities at said facility. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of Spa 23.
2. I understand and am aware that strength, flexibility, and aerobic exercise, include the use of equipment, is a potentially hazardous activity. I also understand that fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.
3. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation in any of the activities and programs of **Spa 23** or use of equipment or machinery. I do hereby acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise, and use of exercise and training equipment so that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given my physician's permission to participate, or that I have decided to participate in activity and/or use equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities.
4. I do hereby acknowledge that any claims, actions, disputes or controversies of every kind or nature that I may allege against **Spa 23** or which I may allege have arisen as a result of my gaining membership or being allowed to participate in the activities or programs of **Spa 23**, shall be required to be submitted to binding arbitration with the "American Arbitration Association," which organization's rules shall apply and control. **Spa 23** shall not be limited to arbitration in pursuit of any claim, action, dispute or controversy against me.
5. I understand that if any provision of this agreement shall be held invalid, the remaining provisions shall remain valid and in full force and effect.
6. I hereby certify that I have read and understand the above in its entirety and agree to all of the provisions contained herein, and that I am at least 18 years of age.

Signature of Participant (or Parent/Guardian if minor)

Date

Witness's Signature

Date