

# YARDVILLE CYO SUMMER DAY CAMP 2023



**JUNE 19 – AUGUST 18**

453 Yardville Allentown Rd.  
Yardville, NJ 08620  
Phone: (609) 585-4280, EXT. 116  
Fax: (609) 585-2435  
[www.cyomercer.org](http://www.cyomercer.org)



## CAMP FEES

		rate before June 1 <sup>st</sup>	rate after June 1 <sup>st</sup>
⬇ Whole Summer	June 19 – August 18	\$2,300.00	\$2,350.00
⬇ Session I (3 weeks)	June 19 – July 7	\$ 975.00	\$1,000.00
○ *(Camp Closed Tuesday, 7/4)*			
⬇ Session II	July 10 – July 21	\$ 725.00	\$ 750.00
⬇ Session III	July 24 – August 4	\$ 725.00	\$ 750.00
⬇ Session IV	August 7 – August 18	\$ 725.00	\$ 750.00

## DISCOUNTS "Save More - Bigger Discounts!"

- Multiple child discounts for whole summer registration is \$100.00 deduction per child
- Multiple child discounts for individual session registration is \$50.00 deduction per child for the second and subsequent children (first child must pay in full)
- Pay in full by February 28th, 2023 and receive a \$50.00 discount per child for whole summer registrations and a \$25.00 discount per child for individual session registration.



## Other Information

- ✦ Program is for children ages 5 – 13
- ✦ Outstanding, experienced staff
- ✦ American Camp Association accredited
- ✦ Lunch Plan, Extended Care available (see back side of this flyer)
- ✦ Snack provided free each afternoon
- ✦ Free T-Shirt to each camper
- ✦ **Camp Hours** 9:00am – 4:00pm      **Extended Care** 7:30am – 5:30pm
- ✦ Beautiful, well-maintained 23 acre property
- ✦ Also offered at this CYO site in the summer are the following programs:
  - ✦ Pre School Program
  - ✦ C.I.T. Program (Counselor In Training)
  - ✦ Evening Swim Lessons
  - ✦ Weekend Picnic Rentals



### SAFETY FIRST!!

The CYO will continue to operate all of our programs in full compliance with state and local safety protocols related to COVID – 19.

**For more information, see us on the web or call 609-585-4280.**

[www.cyomercer.org](http://www.cyomercer.org)



(OVER)

**LUNCH PLAN:**

Whole Summer	<b>\$250.00</b>
Session I	<b>\$120.00</b>
Session II – IV	<b>\$ 105.00</b>



**EXTENDED CARE: Second and subsequent children are 50% off**

- ✘ Extended Care AM only                   **\$60.00** per week
- ✘ Extended Care PM only                   **\$65.00** per week
- ✘ Extended Care AM & PM               **\$75.00** per week

**ACTIVITIES**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>✓ Red Cross Swim Lessons / Free Swim</li> <li>✓ Miniature Golf</li> <li>✓ Clubs: photography, fishing, radio, basketball, soccer, dance, Wii &amp; others</li> <li>✓ Special Events – Talent Show, Carnival, Laser Tag &amp; "COLOR WARS"</li> <li>✓ Cargo Net</li> <li>✓ Carpetball</li> </ul> | <ul style="list-style-type: none"> <li>✓ Free Arcade Games</li> <li>✓ Soccer, Basketball,</li> <li>✓ Volleyball, Wiffle Ball</li> <li>✓ Kick Ball, GaGa</li> <li>✓ Playgrounds</li> <li>✓ Amphitheatre</li> <li>✓ Much, much more</li> </ul> |
|--|--|



**Monsignor Toomey Scholarship**

Scholarship opportunities are available through the fund of our founder, the late *Monsignor Leonard Toomey*. Interested candidates should call Patrick Hardiman at 609-585-4280 ext. 102 or via email [phardiman@cyomercer.org](mailto:phardiman@cyomercer.org) for an application and details to see if you qualify. The scholarships are available for sessions II, III, & IV in the amount of \$625.00. \$100.00 co-pay is required by the parents.

# CYO DAY CAMP

## 2023 REGISTRATION

Name of Child	Age	Date of Birth	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Address	City		Zip Code	
School	Grade entering in the Fall			
Mother's Name	Father's Name			
Home Phone #	Home Phone #			
Work Phone #	Work Phone #			
Cell #	Cell #			
Email Address	Email Address			

### Rates / Selection

_____	Registration Fee (\$50.00)		<b>Before 6/1</b>	<b>After 6/1</b>
_____	Whole Summer:	June 19 – August 18	\$2,300.00	\$2,350.00
_____	Session 1:	June 19 – July 7	\$975.00	\$1000.00
_____	Session 2:	July 10 – July 21	\$725.00	\$750.00
_____	Session 3:	July 24 – August 4	\$725.00	\$750.00
_____	Session 4:	August 7 – August 18	\$725.00	\$750.00
_____	Lunch Plan	- Whole Summer	\$250.00	
_____	Lunch Plan	- Session 1	\$120.00	
_____	Lunch Plan	- Session 2, 3 & 4	\$105.00 each	
_____	Extended Care AM Only		\$60.00 per week	
_____	Extended Care PM Only		\$65.00 per week	
_____	Extended Care AM & PM		\$75.00 per week	

All initial registrations must be accompanied by a \$250.00 deposit per child (applied toward total camp fee) and the \$50 registration fee. Registration fee is per family for new campers only and is non-refundable. Registration takes place at the CYO Day Camp (453 Yardville-Allentown Rd.) Office Hours: 7:30am – 6:00pm Mon – Fri

There are NO REFUNDS FOR MISSED DAYS, ILLNESSES, VACATIONS OR DISMISSAL FOR DISCIPLINARY REASONS. All Camp Fees must be paid in full by June 1<sup>st</sup>. If registering after June 1<sup>st</sup>, camp tuition must be paid in full at time of registration. All forms must be submitted and completed before a camper is considered fully registered.

### Discounts:

Register and pay in full before February 28, 2023 for a \$50.00 discount on Whole Summer Camp or \$25.00 discount for individual sessions per child.

If registering more than one child:

Whole Summer - \$100.00 per child

Individual Session - \$50.00 deduction for the second and subsequent children (the first child must be paid in full)

Extended Care – 2<sup>nd</sup> and subsequent child are 50% off

FOR CREDIT CARD PURCHASES ONLY:

Name on Credit Card: \_\_\_\_\_

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Total Amount to Charge: \$ \_\_\_\_\_

**WE ACCEPT**



### Refund Policy

100% refund given until March 31, 2023  
 75% refund given until April 30, 2023  
 50% refund given until May 31, 2023  
**NO REFUND given after May 31, 2023**

**Total Due:**  
\$

# WAIVERS

I certify that my child's physical condition is satisfactory for participating in the above CYO Program. I recognize and acknowledge that there are certain risks of physical injury in any recreational program and I hereby assume full responsibility for any expenses incurred as a result of my child's participation in the CYO Program.

I agree to: (a) waive and relinquish; (b) fully release and discharge; and (c) indemnify and hold harmless the Mercer County CYO, the Diocese of Trenton and their officers, agents and employees from any and all claims from injuries, damage or loss which may accrue to me on account of my child's participation in the CYO Program.

X \_\_\_\_\_  
Signature Date

I give \_\_\_\_\_ / do not give \_\_\_\_\_ the CYO permission to use any photographs or video footage of my child for any promotional or other legitimate reason including newspapers, brochures, website, social media, etc...

X \_\_\_\_\_  
Signature Date

I hereby acknowledge that I have been given to read a CYO Day Camp Parent Handbook which includes: "Information to Parents", release policy, disciplinary and termination policy and a fee & payment policy as well as our refund policy. These documents are available in the CYO main office.

X \_\_\_\_\_  
Signature Date

## Pick Up Authorization

Please list any additional people other than those that appear on the front of this registration form that are permitted to pick up your child from the CYO Day Camp. Are there any custody problems? \_\_\_\_\_  
If so, on a separate sheet of paper, attach to this registration form, please briefly explain. We will need all court documentation (if applicable) prior to the start of camp. Proper photo I.D. is required for picking up. Only those names listed on this form can pick up a camper.

\_\_\_\_\_  
Name Phone # Relationship

\_\_\_\_\_  
Name Phone # Relationship

\_\_\_\_\_  
Name Phone # Relationship

For Office Use

# Health History and Examination Form for Children, Youth and Adults Attending Camps

FM 08N

Dates of Camp Attendance \_\_\_\_\_

**Suggested for resident camp use.**

Developed and approved by  
**American Camping Association®**  
American Academy of Pediatrics

Mail this form to the address below by \_\_\_\_\_ (date)

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians of minors or by adults

themselves. Update required annually. Health exam (back page) must be completed by approved licensed medical personnel at least every two years.

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_  
Last First Middle

Home address \_\_\_\_\_  
Street address City State Zip

Social security number of participant \_\_\_\_\_ Gender:  Male  Female

Custodial parent/guardian \_\_\_\_\_ Phone \_\_\_\_\_

Home address (if different from above) \_\_\_\_\_  
Street address City State Zip

Business address \_\_\_\_\_ Phone \_\_\_\_\_  
Street address City State Zip

Second parent or guardian or emergency contact \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street address City State Zip

Business address \_\_\_\_\_ Phone \_\_\_\_\_

If not available in an emergency, notify:

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street address City State Zip

### Insurance Information

Is the participant covered by family medical/hospital insurance?  Yes  No

If so, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

► **Photocopy of front and back of health insurance card must be attached to this form.**

### Important — These boxes must be complete for attendance\*

**Parent/Guardian Authorizations:** This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment,

referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staffer \_\_\_\_\_  
Printed Name \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

\*If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Year

Cabin or Group

Name

## Health History

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the

completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

**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.

_____	_____
_____	_____
_____	_____

## MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original

packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer: \_\_\_\_\_

\_\_\_\_\_

## RESTRICTIONS

The following restrictions apply to this individual.

### Dietary

Does not eat red meat

Does not eat pork

Does not eat eggs

Does not eat poultry

Does not eat seafood

Does not eat dairy products

Other (describe) \_\_\_\_\_

**Explain any restrictions to activity** (e.g. what cannot be done, what adaptations or limitations are necessary)

_____
_____
_____

**General Questions** (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease? .....	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition? ...	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized? .....	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery? .....	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury? .....	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months? .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious? .....	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation? .....	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear? .....	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking? .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections? .....	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history? .....	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting? .....	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures? .....	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought? .....	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise? ...	<input type="checkbox"/>	<input type="checkbox"/>			
14. Ever had high blood pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur? .....	<input type="checkbox"/>	<input type="checkbox"/>			
16. Ever had back problems? .....	<input type="checkbox"/>	<input type="checkbox"/>			

**Please explain any "yes" answers, noting the number of the questions.**

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Which of the following has the participant had? <input type="checkbox"/> Measles <input type="checkbox"/> Chicken pox <input type="checkbox"/> German measles <input type="checkbox"/> Mumps <input type="checkbox"/> Hepatitis A <input type="checkbox"/> <b>Hepatitis B</b> <input type="checkbox"/> <b>Hepatitis C</b>  TB Mantoux Test Date of last test _____ Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Please give all dates of immunization for: Vaccine:            Dates:    Mo/Yr    Mo/Yr    Mo/Yr    Mo/Yr    Mo/Yr    Mo/Yr DTP _____ TD (tetanus/diphtheria) _____ Tetanus _____ Polio _____ MMR _____ or Measles _____ or Mumps _____ or Rubella _____ Haemophilus influenza B _____ Hepatitis B _____ Varicella (chicken pox) _____
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**Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.**

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Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_  
 Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_

**Health Care Recommendations by Licensed Medical Personnel**

I examined this individual on \_\_\_\_\_. (ACA accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.)

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant  is  is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Recommendations and Restrictions at Camp**

Treatment to be continued at camp

\_\_\_\_\_  
\_\_\_\_\_

Medications to be administered at camp (name, dosage, frequency)

\_\_\_\_\_  
\_\_\_\_\_

Any medically-prescribed meal plan or dietary restrictions

\_\_\_\_\_  
\_\_\_\_\_

Known allergies

\_\_\_\_\_  
\_\_\_\_\_

Description of any limitation or restriction on camp activities

\_\_\_\_\_  
\_\_\_\_\_

Additional information for health care staff at the camp

\_\_\_\_\_  
\_\_\_\_\_

<p><b>Signature of Licensed Medical Personnel</b> _____</p> <p>Printed _____ Title _____</p> <p>Address _____</p> <p>Phone _____ Date _____</p>
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For camp use only

<p><b>Screening Record</b></p> <p>Date screened _____ Time _____ am _____ pm</p> <p>Meds received _____</p> <p>_____</p> <p>Updates/additions to health history noted <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None required</p> <p>Current health needs identified _____</p> <p>_____</p> <p>Observational notes _____</p> <p>_____</p> <p>Screened by _____</p>
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# CYO DAY CAMP

## Health History and Examination Form Addendum

Name of Camper: \_\_\_\_\_

Has anything changed with your child's health, including allergies, since you submitted your child's Health Form to the CYO Day Camp?

Is there anything that you would like to make us aware of, even if it has already been listed on your child's Health History Form, concerning your child's Health?

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_

**CYO DAY CAMP – YARDVILLE**

**EXTENDED CARE**

NAME OF CHILD	AGE	DATE OF BIRTH	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
ADDRESS		CITY		
MOTHER'S NAME		FATHER'S NAME		
HOME PHONE #		HOME PHONE #		
WORK PHONE #		WORK PHONE #		
CELL #		CELL #		

WS _____	SES. 1 _____	SES. 2 _____	SES. 3 _____	SES. 4 _____
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AM ONLY \_\_\_\_\_ Drop Off Time: \_\_\_\_\_

PM ONLY \_\_\_\_\_ Pick Up Time: \_\_\_\_\_

AM and PM \_\_\_\_\_ Drop Off Time: \_\_\_\_\_ Pick Up Time: \_\_\_\_\_

**PICK UP AUTHORIZATION**  
PLEASE LIST ANY ADDITIONAL PEOPLE PERMITTED TO PICK UP YOUR CHILD FROM THE CYO DAY CAMP

NAME \_\_\_\_\_ PHONE # \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_ PHONE # \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_ PHONE # \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

# FOOD PROGRAM REGISTRATION CYO DAY CAMP YARDVILLE

FOR CYO OFFICE USE ONLY

GROUP \_\_\_\_\_

CHILD'S NAME : \_\_\_\_\_

WHOLE  
SUMMER  
\$250.00

SESSION 1  
\$120.00

SESSION 2  
\$105.00

SESSION 3  
\$105.00

SESSION 4  
\$105.00

PLEASE LIST ANY FOOD ALLERGIES YOUR CHILD MAY HAVE :

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