



NATIONAL FEDERATION FOR JUST COMMUNITIES™ of Western New York, Inc.

SHERIFF/YOUTH “LIVE-IN” CAMP – CRADLE BEACH CAMP, ANGOLA, NY
MONDAY, AUGUST 20th - FRIDAY, AUGUST 24th, 2018

REGISTRATION FORM – (TO BE COMPLETED BY APPLICANT AND PARENT(S)/GUARDIAN(S))

Applicant's Name: _____ Age: _____
(Last, First, M.I.)

Gender _____ Date of Birth ____/____/____ Email: _____

School: _____ Grade: _____

Home Address: _____
(including City/Town, Zip)

Home Phone: _____ Mobile Phone: _____

Parent(s)/Guardian(s): _____ Work Phone: _____

To help us plan for a diverse group, please complete the requested information. Please note: we welcome applicant of all identities.

Race /Ethnicity of Applicant: Native American ____ Asian/Pacific Island ____ African American ____
Latino/Hispanic ____ Multi ____ Middle Eastern ____ Caucasian ____

Other(s), please list: _____, _____, _____

Religion/Faith Tradition of Applicant:

Christian ____ Islam ____ Jewish ____ Buddhism ____ Hindu ____ Baha’i ____ Atheist ____ Other* ____

***Other, please list:** _____, _____, _____

NOTE: There is no cost for attending the camp.

IF SELECTED, YES, I PLAN ON ATTENDING 2017NFJC – SHERIFF/YOUTH “LIVE-IN” CAMP.

Applicant Signature: _____ Date: _____

Parent Signature: _____ Date: _____

SHERIFF/YOUTH CAMP – CRADLE BEACH CAMP
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RECOMMENDATION FORM

TO BE COMPLETED BY RECOMMENDING/REFERRING ADULT

Applicant's Name: _____ Age: _____ Grade: _____

Recommendation made by: _____ Title: _____

School/Organization/Employer: _____

Address: _____ Work Phone: _____

Fax: _____ Email: _____

Relationship to Applicant: Teacher, Counselor, Other: _____

Applicant's involvement in school, work, or community activities:

In one sentence, identify one contribution this applicant would make to the camp experience:

Please note in which NFJC Programs has participated, if any: _____

Additional reasons for recommendation:

Please mail or fax in this application no later than *June 15, 2018*.

**The NFJC of WNY, Inc.
360 Delaware Ave, Suite 106
Buffalo, New York 14202
716.853.9596 – phone
716.852.0046 – fax**



PROGRAM PARTICIPATION CONSENT FORM

INSTRUCTIONS:

Please read carefully and sign. If the applicant is under 18 years of age, both the applicant and his/her parent or guardian must sign. If either signature is missing, the application will not be processed.

I understand that the NFJC Sheriff /Youth “Live-In” Camp is an intensive human relations program that deals with mature subject matters. I understand that discussion topics may include values clarification, self-reflection, stereotypes and prejudice, interpersonal communication, racial identity, racism, sexism, heterosexism, classism, family issues, institutional and personal power, and other issues of oppression.

I understand that participants and staff often find it to be an emotional experience. Throughout the weekend participants may experience confusion, anger, joy, sadness, frustration, hope and other emotions related to the challenging issues of bigotry as they learn about the impact discrimination has on the lives of individuals. Participants will be asked to complete a series of written evaluations during and after the program. I hereby grant permission for my child to complete evaluation questionnaires.

I assure you that my child has, and I have, no known mental or emotional disorders or sensitivities that would interfere with my/my child’s participation, and that I am/my child is capable of handling the subject matter and emotional nature of this program.

I understand that, although NFJC has taken precautions to provide proper organization, supervision, instruction, and equipment for each activity, it is impossible for NFJC to guarantee absolute safety. I also understand that each participant shares the responsibility for safety during all activities, and I assume that responsibility for myself/for my child. I waive any claim that may arise against the Board of Directors of the NFJC of WNY, Inc. and/or its employees, agents, volunteers or lessors, including those claims that may arise from the negligence of NFJC of WNY, Inc.; its Board of Directors, and/or its employees, agents, lessors or volunteers.

For parents/guardians:

If the President or Program Director of the NFJC must send me/my child home for any reason, I agree to pick up my child within four hours of the President’s or Program Director’s call. I understand that I may be called at any time of the night or day to arrange for my child’s transportation home and that I will be responsible for all costs associated with such transportation.

If my/my child’s medical information should change prior to the Camp, I will notify NFJC of any new conditions, medications, limitations, etc.

I have read and understand all the registration documents required for my/my child’s participation in this NFJC program.

Applicant’s Name (print): _____

Applicant’s Signature: _____ Date: _____

Parent/Guardian’s Name (print): _____

Parent/Guardian’s Signature: _____ Date: _____



PROGRAM PARTICIPATION CONSENT FORM [CONTINUED]

Personal Information

Please respond to the following:

- I do grant permission for my/my child’s name, phone number and additional contact information to be distributed to other participants on the program roster.
- I do not grant permission for my/my child’s name, phone number and additional contract information to be distributed to other participants on the Institute roster.

Applicant’s Initials: _____ Parent/Guardian’s Initials: _____

Photo Release

I am the parent or legal guardian of _____ (child’s name), who will be participating in the NFJC Sheriff & Youth “Live-In” Camp and/or follow-up activities, sponsored by The National Federation for Just Communities of Western New York (NFJC of WNY).

I understand that my child, alone or with other participants and/or NFJC Staff, volunteers or representatives, may be interviewed, may provide written or oral statements, and/or may be photographed recorded on film, audio tape, videocassette, or other visual and sound, computerized, telephonic, voice-mail or tape media (“photographs and/or sound/image recordings”) by NFJC and/or other approved by NFJC.

I hereby consent to the foregoing and grant permission, without reservation, to NFJC and/or those approved by NFJC to generate, prepare, advertise, describe and/or publicize NFJC and its work, good will, public education and/or fundraising activities, disseminate, otherwise use and comment upon the photographs and/or sound/image recordings as they may determine, without review by me or my child and without financial or other obligation of any nature to me or my child.

I consent that my child may be identified by name, age and place of residence or otherwise, as NFJC and/or those approved by NFJC may determine.

I release NFJC, it’s Board Members, volunteers, agents, grantors, employees, licensees and assigns from all claims that I or my child may have, or might have, for any cause of action arising out of the taking and/or use of the photographs and/or sound/image recordings as set forth herein.

This consent and release shall continue in effect, without a limitation of time.

- I do consent and agree to the photo release terms mentioned above.
- I do not consent or agree to any of the photo release terms mentioned above.

Parent/Guardian’s Name (print): _____

Parent/Guardian’s Signature: _____

Relationship (if signing for a minor): _____ Date: __/__/__

Signature of Applicant: _____



MEDICAL INFORMATION/HISTORY FORM

PARENTS: Please complete front and have your physician complete the reverse side. PLEASE PRINT

Applicant's Name: _____ Gender: _____ Birth date: _____ Age: _____

Parent/Guardian: _____ Home Phone: _____

Address: _____ Work Phone: _____

IN CASE OF EMERGENCY:

1 Name: _____ Relationship: _____

Address: _____ Zip: _____ Phone: _____

2 Name: _____ Relationship: _____

Address: _____ Zip: _____ Phone: _____

INSURANCE INFORMATION Name on Policy: _____

Carrier: _____ ID Number: _____

Group Policy Number: _____

List any other important insurance information: _____

Child's Physician/Pediatrician: _____ Phone: _____

Child's Dentist/Orthodontist: _____ Phone: _____

MEDICAL AUTHORIZATION FORM

This must be notarized by a Notary Public and signed by parent/guardian in Notary's presence.

Applicant's Name: _____ Grade in Fall: _____

In the event that my child is injured or becomes ill, I hereby give permission to the Camp Director or the physician, or the hospital selected by the Camp Director/NFJC to hospitalize and secure proper medical treatment for my child, including, but not limited to: ordering injections, anesthesia, or surgery. I understand that I will be held financially responsible for all out-of-camp medical treatments, costs, and/or medications as prescribed.

Signature of Parent/Guardian: _____ Date: _____

Signed by Notary Public: _____ Date: _____

NOTARY SEAL

Place of Execution: _____ Date: _____



IMMUNIZATION AND HEALTH HISTORY

Must meet standards set by NYS Department of Health

Applicant's Name _____ Age: _____ Height: _____

Weight: _____ Blood Pressure: _____ Urinalysis: _____

Vaccines	Basic Immunizations	Boosters
Diphtheria	1.	1.
Pertussis	2.	2.
Tetanus	3.	3.
Tetanus/Diphtheria TD		
Tetanus		
Oral Polio (Sabin) TOPV	1.	
	2.	
Injectable Polio (Salk)		
Measles/Mumps/Rubella MMR		
Other		
Tuberculin test date (most recent)		
Haemophilus Influenza b (HIB)		
Hepatitis B		

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child have any allergies? If yes, to what _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child have seasonal hay fever? If yes, when _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child have asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Has child ever had a reaction to poison ivy? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has the child ever had a reaction to any insect stings? If yes, please attach explanation. |
| <input type="checkbox"/> | <input type="checkbox"/> | Has the child had chicken pox? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child have frequent ear infections? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child have tubes in ear(s)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child wear ear plugs? If yes, is parent sending plugs? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child wear contact lenses? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child have heart defect/disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child have any bleeding/clotting disorders? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has child ever had convulsions/seizures? |
| | | If yes, explain and give dates: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child suffer from headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child have diabetes? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does child have chronic/recurring illnesses? If yes, please attach explanation. |
| <input type="checkbox"/> | <input type="checkbox"/> | Operations/serious injuries? If yes, please attach explanation. |
| <input type="checkbox"/> | <input type="checkbox"/> | Activities to be encouraged: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Activities to be restricted: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dietary restrictions? If yes, to what _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is child on medications? If yes, what: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do medications need to be given/taken while at camp? If yes, list: _____ |

I have examined the applicant herein described and have reviewed the Health History. It is my opinion that this applicant is physically able to engage in camp activities, except as noted above.

Examining Physician's Signature: _____ Date of Physical: _____

Physician's Address _____ Phone: _____

Medication: _____ Dose: _____ Frequency: _____