UNION LEAGUE BOYS & GIRLS CLUBS

Camper Name_____

CAMP
UNION LEAGUE BOYS & GIRLS CLUBS

Registration Packet

Camper Name: _____
Gender: _____ Date of Birth: _____/_____/_____

I want my child picked up (8am on the first day of the session) **and dropped off** (noon on the last day of the session)
___ Barreto (1214 N Washtenaw, Chicago)
___ Club One (2157 W 19th St, Chicago)
___ Stagg School (7424 S Morgan, Chicago)
___ I am a military family who lives in the north suburbs of Chicago therefore will make plans with the Camp Director

Sessions Camper is attending:
_____ 1 _____ 2 _____ 3 _____ 4 _____ 5

For office use only

___ 1 $50	___ Cash	___Check	___ Title XX	___ MYO	___ Other	_____ Date
___ 2 $100	___ Cash	___Check	___ Title XX	___ MYO	___ Other	_____ Date
___ 3 $100	___ Cash	___Check	___ Title XX	___ MYO	___ Other	_____ Date
___ 4 $100	___ Cash	___Check	___ Title XX	___ MYO	___ Other	_____ Date
___ 5 $50	___ Cash	___Check	___ Title XX	___ MYO	___ Other	_____ Date

Notes

_____

_____

_____

_____

_____

_____

UNION LEAGUE BOYS & GIRLS CLUBS

Camper Name_____

CAMP
UNION LEAGUE BOYS & GIRLS CLUBS

CONSENT

The attached health exam is correct, current, and complete as far as I am aware. The child herein described has permission to engage in all Union League Boys & Girls Clubs Camp, hereafter referred to as Camp, activities including Adventure High/Low Ropes Course, except as noted.

I give my permission to camp to provide routine healthcare, administer medications, and seek emergency medical treatment in the event of an emergency. I authorize Camp to obtain and exchange health information for the above named Camper and agree to the release of any records necessary for insurance purposes. I give my permission to Camp to arrange all necessary transportation for my child.

I give my permission of any photograph, video, or other visual representation of my child to be used for publicity and marketing of Camp including any social media.

I understand that camp is not responsible for any lost, stolen, or damaged camper property.

I give permission for my child to attend any off-site field trips during their session(s) attending camp.

I understand that my enrollment is not complete until I have submitted all necessary documents, forms, and sent payment, if applicable.

I understand that if my child is unable or unwilling to complete a session at Camp, I will be notified. If Camp staff and I together cannot resolve the behavior/medical situation, I understand the Camp staff can determine my child is ineligible to remain at Camp and I will need to cooperate with their arrangements for my child's departure.

I certify to the best of my knowledge and belief, that the information provided in this document is true, correct, and complete. I understand that the information will be disclosed only for the purposes of administration of services and that Camp may verify the information I have provided. I understand that I have the right to appeal any adverse action to have a fair hearing of grievance. I request Camping services for the Camper named on the front portion of this document. I understand Camp's values, rules, and regulations and agree to follow them as outlined. I hereby give permission to the camper named in this document to participate in any and all camp activities at Camp and agree to hold free from any and all liability the Union League Boys & Girls Clubs, Camp, its staff and volunteer, the Illinois Department of Human Services, the American Camp Association Illinois or any of their officers for any accident, injury, or disability to the person or property of the aforementioned Camper arising out of or connected with his/her participation in any activity at Camp.

I have read and agree to the terms and conditions above.

_____

Signature Date

_____

Printed Name Relationship

UNION LEAGUE BOYS & GIRLS CLUBS

Camper Name_____

CAMP
UNION LEAGUE BOYS & GIRLS CLUBS

Medical History

Camper Name: _____ DOB: _____/_____/_____

Doctors:

Primary Care:
Name _____ Phone Number: (_____)_____-_____
Dentist:
Name _____ Phone Number: (_____)_____-_____
Orthodontist:
Name _____ Phone Number: (_____)_____-_____
Mental Health:
Name _____ Phone Number: (_____)_____-_____
Other:
Name _____ Phone Number: (_____)_____-_____

Health Insurance

Insurance Company: _____
Policy Number: _____ Group Number: _____
Insurance Company Phone Number: _____

Immunizations	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Latest
DTaP or TDaP	/	/	/	/	/	
Tetanus, Pertussis booster						/
MMR	/	/				/
IPV	/	/	/	/		
HIB	/	/	/	/		
PCV	/	/	/	/		
Hepatitis B	/	/	/			
Hepatitis A	/	/				
Chicken Pox	/	/				
MCV4	/					
H1N1	/	/				
Flu						/

Has the camper ever had surgery? YES / NO

Operation Date

_____

_____

UNION LEAGUE BOYS & GIRLS CLUBS

Camper Name_____

CAMP
UNION LEAGUE BOYS & GIRLS CLUBS

Disease	Test Date	Results
Tuberculosis	/	/

Disease	Last Occurrence
Chicken Pox	/
German Measles	/
Hepatitis A	/
Hepatitis B	/
Hepatitis C	/
Measles	/
Mumps	/
H1N1	/

Does the camper have Asthma? YES / NO

What triggers their asthma?

___ Exercise
___ Fatigue
___ Food item
___ Hydration
___ Respiratory Infection/Common Cold
___ Smoke
___ Stress
___ Other: _____

Does the camper have Diabetes? YES / NO

Check blood sugar at:

___ Breakfast ___ Lunch ___ Dinner ___ Bedtime ___ Other_____

Normal Blood Sugar Range: _____ - _____ Does camper use insulin? YES / NO

Does the Camper have any allergies? YES / NO

Medication allergies: _____

Food allergies: _____

Environmental allergies: _____

Please circle any dietary restrictions the camper follows: No dietary restrictions

Kosher	No Pork	No Wheat
No Dairy	No Poultry	Vegan
No Eggs	No Red Meat	Vegetarian
No Fish	No Seafood	

Please circle any of the health issues the camper has had and explain in the space provided below:

None	Head Injury	Orthodontic Appliance Required at Camp
Abnormal Menstrual History	Heart Murmur	
Anorexia, Bulimia	High Blood Pressure	Seizures, Convulsions
Back Problems	HIV	Short of Breath, Wheezing
Bed Wetting	Immunodeficiency	Skin Problems (itching, rash)
Bleeding/Clotting	Joint Problems (ankles, knees)	Sleep Walking
Diarrhea, Constipation	Knocked Unconscious	Other: _____
Chest Pain, Dizzy, Passing Out	Lice	_____
Glasses, Contacts, or Protective Eyewear	Mono (in the last 12 months)	_____

_____

_____

Please attach additional page with information

Household Sized - Income Application for the Summer Food Service Program

(Rev. 11/17)

Complete one application per household. Please use a pen (not a pencil).

STEP 1 List ALL infants, children, and students up to and including grade 12 who are Household Members

If more spaces are required for additional names, attach another sheet of paper.

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Child's First Name	MI	Child's Last Name	Age	Participant? Yes	or No	Foster Child	Homeless, Migrant, Runaway	Head Start
				☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐

Check all that apply

STEP 2 Do any Household Members (including you) currently participate in any of the following assistance programs: FoodShare (SNAP), W-2 Cash Benefits (TANF), or FDPIR?

☐ Yes ☐ No

If you answered NO > Complete STEP 3. **If you answered YES** > Write a case number here, then go to STEP 4 (Do not complete STEP 3)

Case Number	Program Name
Write only one case number in this space.	Badger Care does not qualify for free meals.

STEP 3 Report Income for ALL Household Members (skip this step if you answered 'Yes' to STEP 2)

Flip the page and review the charts titled "Sources of Income" for more information.

A. Child Income

Child income	How often? Weekly	Bi-Weekly	2x	Monthly
$	☐	☐	☐	☐

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report total **gross** income (before taxes) for each source in whole dollars only (no cents). If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last Name)	C. Earnings from Work	How often? Weekly	Bi-Weekly	2x Month	Monthly	D. Public Assistance/ Child Support/ Alimony/SSI/VA Benefit	How often? Weekly	Bi-Weekly	2x Month	Monthly	E. Pensions/Retirement/ Social Security, Other Income	How often? Weekly	Bi-Weekly	2x Month	Monthly	F. Seasonal Workers, and others with fluctuating income, project the annual income and report here.
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$

G. Total Household Members (Children and Adults)— REQUIRED

H. Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member—REQUIRED or check box if no SSN X X X - X X - ____

Check if no SSN ☐

STEP 4 Contact information and adult signature Return completed form to: Insert your Sponsor mailing address here

I certify (promise) that all information on this application is true and correct, and that all income is reported, unless eligibility is established by receiving FoodShare, W-2 Cash Benefits and/or FDPIR. I understand that this information is given in connection with the receipt of Federal funds, and that agency officials may verify (check) the information; and that deliberate misrepresentation or withholding of information may result in prosecution under applicable State and Federal statutes.

Street Address *If available* Apt #	City	State	Zip	Daytime Phone and Email *Optional*

Printed Name of Adult Completing this Application—REQUIRED	➢ Signature of Adult Completing this Application—REQUIRED	Today's Date *Mo./Day/Yr.*

INSTRUCTIONS Source of Income

Sources of Income for Children

Sources of Child Income	Example(s)
- Gross earnings from work	- A child has a regular full or part-time job where they earn a salary or wages
- Social Security - Disability payments - Survivor's benefits	- A child is blind or disabled and receives Social Security benefits - A parent is disabled, retired, or deceased, and their child receives Social Security benefits
- Income from person outside the household	- A friend or extended family member regularly gives a child spending money
- Income from any other source	- A child receives regular income from a private pension fund, annuity, or trust

Sources of Income for Adults

Earnings from Work	Public Assistance / Alimony / Child Support	Pensions / Retirement / All Other Income
- Gross salary, wages, cash bonuses - Net income from self-employment (farm or business); **FARM**—refer to line 18 of the 1040 or line 34 from Schedule F; **BUSINESS**—refer to line 12 of 1040 or line 31 from Schedule C. If you are in the U.S. Military: - Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) - Allowances for off-base housing, food and clothing	- Unemployment benefits - Worker's compensation - Supplemental Security Income (SSI) - Cash assistance from State or local government - Alimony payments - Child support payments - Veteran's benefits - Strike benefits	- Social Security (including railroad retirement and black lung benefits) - Private pensions or disability benefits - Regular income from trusts or estates - Annuities - Investment income - Earned interest - Rental income - Regular cash payments from outside household

OPTIONAL Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for meals.

Check one ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Check one or more ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number are not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, and with auditors for program reviews and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW Washington, D.C. 20250-9410

Fax: (202) 690-7442; or

Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Do not fill out For Sponsor Use Only

Annual Income Conversion: Weekly x 52, Bi-weekly (Every 2 Weeks) x 26, Twice a Month x 24, Monthly x 12
Monthly Income Conversion: Weekly x 4.33 or Every 2 weeks x 2.15

Total Income	How often?					Household Size	Categorical Eligibility	Eligibility	
	Weekly	Bi-Weekly	2x Month	Monthly	Yearly			Needy	Non-Needy
	☐	☐	☐	☐	☐		☐	☐	☐

Categorical Eligibility = FoodShare, W-2 Cash Benefits, or FDPIR participant

Signature of Determining Official ➢ Today's Date *Mo./Day/Yr.*

CAMPER REGISTRATION FORM

ILLINOIS DEPARTMENT OF HUMAN SERVICES APPLICATION FOR DFI TITLE XX CAMPING SERVICES THROUGH THE American Camp Association, Illinois

"Funding provided in part by the Illinois department of Human Services"

PARENT/GUARDIAN NAME:			TELEPHONE NUMBER:		CAMP AGENCY NAME:
Parent/Guardian ADDRESS CITY	STATE	ZIP CODE	COUNTY		Teen REACH Agency Name:

CAMPERS - I am requesting DFI Title XX Camping Services for the following camper(s): I understand that I MAY NOT register these same campers for more than one camp in the same season (Summer, Fall, Winter, Spring)

A Potential camper must reside in Illinois and indicate they qualify for **any ONE of the following**: Temporary Assistance for Needy Families (TANF) **or** Supplemental Nutrition Assistance Program (SNAP) (previously known as Food Stamps) **or** Medical Services. **Identification Numbers** (Case or Individual Client ID#) **are NO LONGER NEEDED.**

NAME of CAMP: _____ **CAMP SESSION** from: _____ to: _____

Camper: **LAST NAME:** _____ **FIRST NAME:** _____ **MI:** _____

Gender: Please write the gender of the camper: _____

Race/Ethnicity: Caucasian ☐ - African American ☐ - Hispanic ☐ - Asian ☐ - American Indian ☐ - Other ☐

Camper's Primary Spoken Language: English ☐ - Spanish ☐ - Other ☐ _____

Age as of JUNE (this year): _____

Birthdate: _____ **Grade as of SEPTEMBER** (this year): _____

PARENTAL CERTIFICATION AND AUTHORIZATION - I certify that to the best of my knowledge and belief, the information provided is true, correct and complete. I understand that the information will be disclosed only for purposes of administration of services, and that IDHS may verify the information I have provided. I understand that I have the right to appeal any adverse action and to have a fair hearing of grievance. I request camping services for the person(s) named as camper(s) above and give my permission for them to receive medical treatment, including surgery, in case I cannot be reached. I HEREBY GIVE PERMISSION FOR THE PERSON(S) NAMED AS CAMPER(S) ABOVE TO PARTICIPATE IN THE CAMPING PROGRAM AT CAMP(S) NAMED ABOVE AND AGREE TO HOLD FREE from any and all liability the Illinois Department of Human Services, the American Camp Association, Illinois and the Private Agencies and Camps, or any of their Officers, Employees and Members, and waive all claims for damages or recompense for any accident, injury or disability to the person or property of the aforementioned camper(s) arising out of or connected with his/her participation in any of the activities of the Camping Program.

_____ _____

Signature of Client Date

CAMP REGISTRAR USE ONLY

CONFIRMATION OF REGISTRATION AND CERTIFICATION OF ELIGIBILITY

I have asked and received a qualifying answer from parent/guardian concerning the camper eligibility of the camper(s).

_____ _____ _____

Registrar's Signature Date Location

American Camp Association, Illinois (ACA IL) 2016

UNION LEAGUE BOYS & GIRLS CLUBS

Camper Name_____

CAMP
UNION LEAGUE BOYS & GIRLS CLUBS

Has the camper traveled outside of the United States in the last year? YES / NO
Where? _____

Please circle any of the mental health issues the camper has and explain in the space provided below: No mental health issues

Attention Deficit Disorder (ADD or ADHD)
Depression
Eating Disorder
Learning or Processing Challenge
Obsessive-Compulsive Disorder
Panic, Anxiety Disorder
Substance Abuse
Other Mental, Emotional, or Social Health Issues

_____
_____

Will the camper take any prescriptions while at camp? YES / NO

Name	Dosage	Time

The following medications are stocked in the infirmary. Please cross off any medications you DO NOT want your child to take.

Acetaminophen (Tylenol)
Antidiarrheal (Maalox)
Bismuth Subsalicylate (Pepto Bismol)
Calamine Lotion
Chamomile Tea
Chlorpheniramine Maleate (Robitussin Cough & Allergy Syrup)
Cough Drops
Diphenhydramine (Benadryl)
Guaifenesin (Mucinex, Robitussin Cough & Cold)
Ibuprofen (Advil)
Loratadine (Claratin)
Poison Ivy Treatment (Ivy-Dry)
Pseudoephedrine Hydrochloride (Advil Cold & Sinus)
Pediculosis Treatment (Nix)
Tolnaftate (Tinactin)
Bacitracin/Antimicrobial (antibiotic ointment)
Betadine (iodine)
Burn Cream
Orabase B or Abreva
Carmax
Immodium
Visine
Swimmers Ear Drops
Hydrocortisone Cream 1%
Sting Releif
Tums
Chloriseptic Mouth Spray
Sunscreen
Midol

UNION LEAGUE
BOYS & GIRLS CLUBS

Youth Membership Form
Forma de Membrecía de Joven

Barreto	1214 N Washtenaw Ave 60622	773.772.2187
Clemente	1147 N Western Ave 60622	773.534.4072
Club One	2157 W 19th St 60608	312.777.3222
Club Two	936 N Ashland Ave 60622	773.535.7010
CICS Bucktown	2235 N Hamilton Ave 60647	773.645.3321

Office Use Only

Club ID Number_____
Paid_$_____
Payment Received by_____
Date_____
Comments_____

Youth Information / Información del Niño/a

Youth First Name/ Primer Nombre del Niño/a	Middle Name/ Segundo Nombre del Niño/a	Youth Last Name/ Apellido del Niño/a

Nickname/Apodo _____ Date of Birth/Fecha de Nacimiento _____

Gender/Género: F □ M □ or/o _____ Age/Edad: _____

School/Escuela: _____ Grade/Grado: _____

Members' Status/Estado Actual:
- □ New/Nuevo
- □ Renewal/Reingreso

Ethnicity (circle one)/Grupo Étnico (seleccione): African American Asian American Caucasian Hispanic Native American Multiracial Other

Home Address/Dirección de Residencia _____ City/Ciudad _____ State/Estado _____

Zip Code/ Código Postal _____ Telephone Number/ Teléfono de Residencia _____ Parent Email Address/ Correo Electrónico del Padre _____

□ Parent or guardian is active, reserve, or retired military/Seleccione si los padres o guardianes estén o estarán en el militario

Guardian's Information/Información del Guardián:

(1) First Name/Primer Nombre | Last Name/Apellido | Relationship to Youth/Relación al Niño/a

Employer and Occupation/Nombre de Empleador y Ocupación | Home Telephone Number/Teléfono

□ Is Guardian Boys & Girls Clubs Alumni? □Yes/Sí □ No (Es el guardián alumno del Boys & Girls Club?) If yes, from where:_____ (en caso afirmativo, de qué Club?) from _____ (Desde) to _____ (Hasta)

(2) First Name/Primer Nombre | Last Name/Apellido | Relationship to Youth/Relación al Niño/a

Employer and Occupation /Nombre de Empleador y Ocupación | Home Telephone Number/Teléfono

□ Is Guardian Boys & Girls Clubs Alumni? □Yes/Sí □ No (Es el guardián alumno del Boys & Girls Club?) If yes, from where:_____ (en caso afirmativo, de qué Club?) from _____ (Desde) to _____ (Hasta)

Household Size/Tamaño Familiar: _____

Family Setting/Grupo Familiar: □ Single Parent/Un Padre o Madre □ Two Parents/Dos Padres □ Other/Otro

Annual Household Income (circle one)/Ingresos Anuales del Hogar (seleccione uno):

$9,000 or less/o menos	$9,001 - $12,000	$12,001 - $15,000	$15,001 - $19,000	$19,001 - $23,000
$23,001 - $28,000	$28,001 - $32,700	$32,701 - $37,500	$37,501 - $42,000	$42,001 +

Youth Medical Conditions & Allergies/Condiciones Médicas & Alergias del Niño/a:

_____

_____

_____

Youth Medications/Medicamentos del Niño/a:

_____

_____

_____

Youth Doctor's Name/
Nombre del Médico

_____

Youth's Hospital or Clinic Name/
Nombre del Hospital o Clínica del Niño/a

_____

Do you have insurance? □ Yes/Sí
¿Tiene aseguranza? □ No/No

Emergency Contact Contacto de Emergencia	Phone Number Número de Teléfono	Relationship to Youth Relación al Niño/a	Authorized for Pick-Up? ¿Autorizado para recoger a su niño?
			Yes/Sí No
			Yes/Sí No
			Yes/Sí No

Circle all programs which apply/Seleccione todos los programas que aplican:

TANF SSDDI SSI LINK Card/SNAP Free/Reduced School Lunch/Lonche reducido o gratis

I, a parent/guardian of the member, have read and explained the rules of membership to the member. I consent to (1) collection of all information about the member from his/her school; (2) member interviews, questionnaires, focus groups, surveys; (3) data summarization and sharing of results with staff, BGCA, and funders; (4) data/information sharing with outside third parties anonymously (5) photographs/videos of the member to be used in Club marketing and reporting; (6) the member's participation in the National Youth Outcomes Initiative of BGCA; and (7) agree the ULBGC will not be responsible for accidents occurring to the member while engaged in Club activities.

Yo, como Padre/Guardián del participante, he leído y explicado las reglas de membrecía al participante. Yo doy mi consentimiento de (1) reunir toda la información de la escuela acerca del participante; (2) entrevistas con el participante, cuestionarios, grupos de enfoque, encuestas; (3) resumen de información y compartir resultados con el personal, participantes y fundadores de BGCA; (4) intercambio de datos con terceros anónimamente; (5) fotografías/videos del participante para uso de comercialización y presentación de informes en el Iniciativa Nacional de los Resultados de la Juventud de BGCA; y (7) estoy de acuerdo con que el ULBGC no será responsable por accidentes que ocurran al participante mientras participa en actividades en el Club.

_____ _____

Parent Signature/Firma de Padre(s) o Guardián **Date/Fecha**