BEREA CITY SCHOOLS
SUMMER DAY CAMP PROGRAM 2024
Big Creek Elementary School
Summer Camp Office 390 Fair Street, Berea, OH 44017
Phone: 216-898-8300
Samantha Turner (Summer Camp Director):
sturner@bereaschools.org
Michelle Nelson: mnelson@bereaschools.org

Students will NOT be enrolled in camp without a completed form and payment of registration fee.

Form must be TYPED

Student Information

NAME:_______________ ______________________________ ________________________
First Name Last Name Preferred Name

ADDRESS:____________ ________________ _______________ ____________
House # Street City Zip

MAIN PHONE NUMBER:___________________________

SEX:_____________________ PRONOUNS:_______________________

2024-25 Grade Level:_____________________

Only BCSD students currently enrolled in grades 1-8 are eligible to participate in camp.

Child's T-shirt Size:_____________________
I understand that each student will receive one free T-shirt to wear on field trips. Youth small-adult XL are available.

Section I: Parent/Guardian Information

Parent/Guardian #1 Name ___________________________________

Parent/Guardian #1 Cell Phone:____________________

Parent/Guardian #1 Work Phone:_____________________

Parent/Guardian #1 Email:__________________________________

Parent/Guardian #2 Name:___________________________________

Parent/Guardian #2 Cell Phone:____________________

Parent/Guardian #2 Work Phone:_____________________

Parent/Guardian #2 Email:__________________________________

Emergency Contacts: List the name(s) of other local persons who you want to be contacted in the event of an emergency or illness if the parent/guardian(s) cannot be reached. Person listed should be able to assist in locating the parent/guardian and at least one person listed must be able to take responsibility for the student in cases where the parent/guardian cannot be reached.

Name:_______________________________ Name:_______________________________

Phone:____________________ Phone:____________________

Section II: Student's Medical Information

Name of Physician/Clinic Hospital:________________________ Physician Phone:________________

Name of Dentist:_______________________________ Dentist Phone:__________________

Name and dosage of any medication taken on a regular basis*:_________________________________

____

***Please complete the attached form for any medications if medication is needed during Camp hours.**

Allergies (food, medication, & environmental) and precautions, reactions, and treatment:______________

____

Please note any special needs your student has or services that they require (i.e. ADHD, Autism, Diabetes, sun sensitivity, etc.)____

Please indicate if your student has a 504/B.I.P/I.E.P: _______

Does staff have permission to review your student's records?_______
*If needed, a meeting to discuss needs may be scheduled prior to the start of camp.

Provide any additional health/enrollment information we should know about your student:
____

Section III: Emergency Authorization

YES or NO:I give my permission for Berea City Schools Summer Day Camp Program to have my student transported to a Hospital/Clinic/Dentist for emergency medical or dental care, or to the nearest available source of assistance. _________

Authorization for Release

I hereby authorize Berea City Schools Summer Day Camp Program to release my student to all individuals listed in **Section 1:** and to the following individuals. *In addition, I understand that for safety purposes, a photo identification will be requested for verification purposes.*

Name:___________________________ *Name:*___________________________

Phone Number:____________________ *Phone Number:*____________________

Denial of Authorization for Release-we will NOT release your students to:

*Name:*________________________________ *Name:*________________________________

I hereby authorize Berea City Schools Summer Camp Program to allow my student to participate in all activities including but not limited to field trips, swimming, arts and crafts, playground, and park activities. Every possible precaution will be exercised to assure the safety and welfare of your student. However, Berea City Schools Summer Camp Program, and its authorized agents shall not be responsible, financially or otherwise, should an accident occur.

I hereby acknowledge that I am responsible for understanding the information in Berea City Schools Summer Camp Program Parent Handbook as it relates to my student's enrollment in the program. I hereby agree to comply with all procedures, policies, and conditions contained in the Parent Handbook, and I understand that my failure to do so may result in termination of my student's participation in the program. Copies of the Parent Handbook are available online at: https://www.berea.k12.oh.us/domain/93

*My student is swimmer-yes or no*______ *Social Media Permission-yes or no:*________

*Parent/Guardian Electronic Signature:*___________________________ *Date:*______________

Parental Agreement of Understanding

Please initial the following statements:

______ I understand that registrations are on a first come first serve basis. The deadline to submit a registration form is May 31st. However, BCSD reserves the right to close registration prior to 5/31/2024 if enrollment is full.

______ I understand that there is no Summer Programming on 6/19/2024 and 7/4/2024.

______ I understand that a non-refundable registration fee of $35 for one student or $50 for siblings in the same household.

______ I understand that Summer Camp is held Monday-Thursday from June 10, 2024-August 1, 2024 at Big Creek Elementary School.

______ I understand Summer Programming requires a three-day minimum enrollment.

______ I understand that all school fees must be up-to-date before students can be registered for Summer Camp

______ I understand that I am responsible for payment of ALL scheduled/registered days of Summer Programming.

I understand that a notice to withdraw or alter my students schedule must reach mnelson@bereaschools.org by 5/31/2024.

______ I understand that should I withdraw my student after 5/31/2024, I am still responsible for all fees per the submitted schedule.

______ I understand that there are no refunds for cancellations, vacations, changes in schedule, etc.

______ I understand that payment for the first four weeks is due on or before 6/3/2024.

______ I understand that payment for the last four weeks is due on or before 6/27/2024.

______ I understand my student will be withdrawn from camp if payments are not received by the dates indicated, but I am still responsible for all fees.

______ I understand that a late fee of $10 will be applied to my student's account for every week that my payment is past due.

______ I understand that I am responsible for dropping off and picking up my students on a daily basis.

______ I understand that this is not an exhaustive list, and all of my responsibilities are outlined in the Parent Handbook, which can be found online at: *https://www.berea.k12.oh.us/domain/93*

____

Name of Student

____ ____________________

Signature of Parent/Guardian **Date**

Student Camp Schedule

Camper's Last Name______________________ **Camper's First Name**______________________

Summer Camp 9AM-4PM

Please check the days your student will be attending.

Monday-Thursday
$155/student/week

3 Days/Week
$120/student/week

Summer Camp	Monday	Tuesday	Wednesday	Thursday
Week 1: 6/10-6/13	☐	☐	☐	☐
Week 2: 6/17-6/20		☐	No Programming 6/19/24	☐
Week 3: 6/24-6/27	☐	☐	☐	☐
Week 4: 7/01-7/03			☐	No Programming 7/4/2024
Week 5: 7/08-7/11	☐	☐	☐	☐
Week 6: 7/15-7/18	☐	☐	☐	☐
Week 7: 7/22-7/25	☐	☐	☐	☐
Week 8: 7/29-8/01	☐	☐	☐	☐

Notice to withdraw or alter a student's camp schedule must reach mnelson@bereaschools.org by 5/31/2024

Student Summer Camp and Before Camp Care Schedule

Camper's Last Name________________________ Camper's First Name________________________

Summer Camp + Before Camp Care: 7:00AM-4:00PM

Please check the days/times your student will be attending

Monday-Thursday
$187/student/week

3 Days/Week
$144/student/week

Summer Camp	Monday	Tuesday	Wednesday	Thursday
Week 1: 6/10-6/13	☐	☐	☐	☐
Week 2: 6/17-6/20		☐	No Programming 6/19/2024	☐
Week 3: 6/24-6/27	☐	☐	☐	☐
Week 4: 7/01-7/03	☐		☐	No Programming 7/4/2024
Week 5: 7/08-7/11	☐	☐	☐	☐
Week 6: 7/15-7/18	☐	☐	☐	☐
Week 7: 7/22-7/25	☐	☐	☐	☐
Week 8: 7/29-8/01	☐	☐	☐	☐

Notice to withdraw or alter a student's camp schedule must reach mnelson@bereaschools.org by 5/31/2024

Student Camp and After Camp Care Schedule

Camper's Last Name________________________ **Camper's First Name**________________________

Summer Camp + After Camp Care: 9:00AM-6:00PM
Please check the days/times your student will be attending

Monday-Thursday
$187/student/week

3 Days/Week
$144/student/week

Summer Camp	Monday	Tuesday	Wednesday	Thursday
Week 1: 6/10-6/13	☐	☐	☐	☐
Week 2: 6/17-6/20		☐	No Programming 6/19/2024	☐
Week 3: 6/24-6/27	☐	☐	☐	☐
Week 4: 7/01-7/03	☐		☐	No Programming 7/4/2024
Week 5: 7/08-7/11	☐	☐	☐	☐
Week 6: 7/15-7/18	☐	☐	☐	☐
Week 7: 7/22-7/25	☐	☐	☐	☐
Week 8: 7/29-8/01	☐	☐	☐	☐

Notice to withdraw or alter a student's camp schedule must reach mnelson@bereaschools.org by 5/31/2024

Student Camp and Before and After Camp Care Schedule

Camper's Last Name________________________ **Camper's First Name**________________________

Summer Camp + Before & After Camp Care: 7:00AM-6:00PM

Please check the days/times your student will be attending

Monday-Thursday
$219/student/week

3 Days/Week
$168/student/week

Summer Camp	Monday	Tuesday	Wednesday	Thursday
Week 1: 6/10-6/13	☐	☐	☐	☐
Week 2: 6/17-6/20		☐	No Programming 6/19/2024	☐
Week 3: 6/24-6/27	☐	☐	☐	☐
Week 4: 7/01-7/03	☐		☐	No Programming 7/4/2024
Week 5: 7/08-7/11	☐	☐	☐	☐
Week 6: 7/15-7/18	☐	☐	☐	☐
Week 7: 7/22-7/25	☐	☐	☐	☐
Week 8: 7/29-8/01	☐	☐	☐	☐

Notice to withdraw or alter a student's camp schedule must reach mnelson@bereaschools.org by 5/31/2024

Prescription and Nonprescription Medication/Treatment Authorization Form

REQUEST MEDICATION/TREATMENT GIVEN AT SCHOOL, SUMMER CAMP or SCHOOL TRIP

Before any medication/ treatment can be given the following must be completed and received by the Health Specialist.

❒ **Prescription** ❒ **Over the Counter**

Student's Name: ______________________ **School/Class:** ______________________

Medication and/or Treatment Name: ______________________

Strength of Medication: ______________________

Dosage, Route, and Time to be Administered: ______________________

Special Instructions for Medication Administration: ______________________

____

Reason for Medication/Treatment: ______________________

Administration Start Date: ______________ Administration End Date: ______________

Possible Adverse Reaction to report to Physician: ______________________

This student received instruction in the use of the above inhaler by my trained staff or me. I recommend that this student carry his/her inhaler on his/her person at all times.	❒ Yes ❒ No
This student received instruction in the use of the above EpiPen by my trained staff or me. I recommend that this student carry his/her EpiPen on his/her person at all times.	❒ Yes ❒ No

Name of Physician: ______________________ Phone: ______________

Signature of Physician: ______________________ Date: ______________

I hereby request and give permission to the nurse, principal, or the principal's designee to administer the prescribed medication listed above to my child as instructed by the physician or authorized healthcare provider with prescriptive authority. My child has taken this medication under my supervision and has had no negative side effects. If applicable, my child may carry his/her inhaler or EpiPen as prescribed by a physician on his/her person during school or school-related activities as stated above. My child and I are aware of the protocols and safety issues at school.

All medication must be clearly labeled and brought to the school (by parent or guardian) in the original container as dispensed by the authorized healthcare provider, physician, or pharmacist. Ask the pharmacist to give you two containers if necessary. Send only the amount of medication that will be administered during school hours or school-sponsored activities. Medications will be kept in the school clinic/office or other secure storage area.

If any revisions to the above plan or prescriber's statement occur, a written revised prescriber's statement must be submitted to the nurse, principal, or the principal's designee. It is understood that it is the student's responsibility to seek the medication at the proper location and time unless s/he is physically or mentally unable to do so. I release and agree to hold the school and its designees harmless from any all liability or injury resulting directly/indirectly from this authorization.

____

Signature of Parent/Guardian Phone (Home/Work/Cell) Date

Date Received at School: ______________ Initials: ________

BCSD
Berea City School District
EXCELLENCE · INTEGRITY · PURPOSE
Serving Berea, Brook Park and Middleburg Heights

REQUEST MEDICATION/TREATMENT GIVEN AT SCHOOL, SUMMER CAMP or SCHOOL TRIP

Dear Parent/Guardian,

To allow students to obtain medical assistance ***for both prescribed and over the counter medication(s) including cough drops, eye drops, Tylenol and etc.*** *during school hours or a school trip, from a Health Specialist, the following is required:*

1. Current Health History and Emergency phone numbers submitted through the OLR Annual Update.
2. The *Prescription and Nonprescription Medication/Treatment Authorization Form* must be completed & signed by physician **and** parent/guardian.
3. **Plan ahead to get forms signed**--faxed orders will be accepted **only** for emergency **changes** **NOT initial order.**
4. **All** student's personal medical supplies or **unexpired** medications, both prescription and over the counter must be brought in by an adult and match the physician order **EXACTLY** and given to the Health Specialist.
5. Supplies must be marked with the student's name and must be stored by the Health Specialist.
6. Students will not be permitted to share medication. Each student must have their own label medication whether prescription or over the counter medication.
7. Provide a picture of your student with their supplies to allow the Health Specialist to safely identify the student.
8. Parent/Guardian will notify the Health Specialist if: the order changes or is discontinued (A new *Prescription and Nonprescription Medication/Treatment Authorization Form)* is required for any changes—we are not permitted to alter the original sheet).
9. Parent/Guardian will contact the Health Specialist with any questions, comments or concerns regarding care.
10. Separate *Prescription and Nonprescription Medication/Treatment Authorization Form* is required if a student is to receive insulin (whether self-administered or staff administered) or Diastat during school.

Thank you for helping us provide a safe & healthy environment for all students!

Medication returned:

Signature of pick up person: ______________________________ Date & Time: ____________

Medication destroyed:

Signature of personnel destroying: ______________________________ Date & Time: ____________

Signature of personnel destroying: ______________________________ Date & Time: ____________