



2025 Summer Camp Registration Form

Camp Wind-in-the-Pines, Leicester, MA | 7:30 AM-5:30 PM

COMPLETE ONE FORM PER CHILD

Camper Name: _____
First Middle Last

Date of Birth: _____

Gender (circle one): Female Gender/Queer Intersex Male Transgender F-M Transgender M-F
Transgender (Unspecified) Other Unspecified Unknown/Undisclosed

School: _____

Grade Entering in Fall 2025: _____

Parent/Guardian Name(s): _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone:

(home) _____ (cell) _____

(work) _____ Email: _____

Please send me my confirmation via email

Camper Shirt Size (t-shirt included with registration):

Youth Small Youth Medium Youth Large Adult Small Adult Medium Adult Large

How did you hear about us? Returning Camper YWCA Website Parent Referral *Baystate Parent*

Facebook/Twitter/Instagram HulaFrog Other: _____

CAMP SESSIONS

Please indicate which camp sessions you are registering for. (Please note that there are no partial sessions. Check as many boxes as apply.)

- | | | | |
|------------------------------------|------------------------------------|------------------------------------|--------------------|
| <input type="checkbox"/> Session 1 | June 23-27 | <input type="checkbox"/> Session 6 | July 28 - August 1 |
| <input type="checkbox"/> Session 2 | June 30 - July 4 (closed July 4th) | <input type="checkbox"/> Session 7 | August 4-8 |
| <input type="checkbox"/> Session 3 | July 7-11 | <input type="checkbox"/> Session 8 | August 11-15 |
| <input type="checkbox"/> Session 4 | July 14-18 | <input type="checkbox"/> Session 9 | August 18-22 |
| <input type="checkbox"/> Session 5 | July 21-25 | | |

I have read, understand and agree to the terms of this application.

Parent/Guardian Signature: _____ Date: _____

AUTHORIZED PICKUP LIST / EMERGENCY MEDICAL RELEASE

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Pick-up List

Anyone picking up a camper must provide a photo I.D. and be listed below.

Parent/Guardian Name: _____ Phone Number: _____

Employer: _____

Parent/Guardian Name: _____ Phone Number: _____

Employer: _____

List up to 3 other people (other than parent/guardian) who are authorized to pick up the camper and should be contacted in case of a medical emergency or emergency pick-up if parent/guardian cannot be reached.

1. Name: _____ Relationship: _____ Phone Number: _____

2. Name: _____ Relationship: _____ Phone Number: _____

3. Name: _____ Relationship: _____ Phone Number: _____

Emergency Medical Release

In case of an emergency, I understand every effort will be made to contact me or the emergency contact persons listed above. In the event that we cannot be reached, I hereby give permission to the physician listed on the form to hospitalize, secure proper treatment and to order anesthesia or surgery for my child.

Physician's Name: _____ Hospital Affiliation: _____

Address: _____

Phone: _____

Medical Insurance Provider: _____ Policy and/or Group #: _____

Medical Conditions

Please check all that apply

- | | | |
|----------------------------------|-------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Depression | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Food Allergies | |

Does your child need to take medication(s) during camp (circle one)? Yes No

If your child requires medication, please specify: _____

Disability (Please specify): _____

The Permission to Administer Medication form must be completed and given to the Camp Director on the first day of each camp session. Medications must be accompanied by the original physician's prescription with clearly written directions. If your child has other special needs (language, learning disability, speech, hearing, food allergies, etc) please contact the Camp Director at 508-767-2505, ext. 125 prior to June 13 or at 508-892-9814 after June 16, 2025.

Medical Release

I authorize the YWCA, as agent for the undersigned, to consent with respect to said minor, to an x-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under general or special supervision of, any physician or surgeon licensed under the provisions of the MA Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital. I understand that the YWCA is not responsible for costs incurred for medical care.

Parent/Guardian Signature: _____ Date: _____

DEMOGRAPHIC INFORMATION

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The YWCA receives funding for a portion of childcare activities. Please choose the appropriate selection for your child:

Household Income

Under \$17,000 \$17,000 - \$49,999 \$50,000 - \$99,999 \$100,000 and above

Race

American Indian/Alaskan Native Asian Black Native Hawaiian/Pacific Islander Hispanic/Latino/a/x Multi Racial
 White Other Race Unknown/Undisclosed

Ethnicity

African American Albanian American American Indian/Alaskan Native Asian Indian Brazilian Cambodian
 Cape Verdean Caribbean Islander Chinese Colombian Cuban Dominican European Filipino Ghanaian
 Guatemalan Haitian Hispanic/Latino/a/x Honduran Japanese Kenyan Korean Laotian Liberian
 Mexican Mexican American Chicano Middle Eastern Portuguese Puerto Rican Russian Salvadoran
 Vietnamese Unknown/Undisclosed
 Other (Please Specify) _____

Primary Language

English Spanish French Arabic Portuguese Haitian Creole Cape Verdean Creole
 Khmer Chinese (any dialect) Korean Vietnamese Russian Somali American Sign Language (ASL)
 Twi Other language not listed Unknown/Undisclosed

Secondary Language

English Spanish French Arabic Portuguese Haitian Creole Cape Verdean Creole
 Khmer Chinese (any dialect) Korean Vietnamese Russian Somali American Sign Language (ASL)
 Twi Other language not listed Unknown/Undisclosed

Disability:

None Developmental/Intellectual/Acquired Brain Injury Other Cognitive Disability D/deaf or hard of Hearing
 Visual Mobility/Motor Mental Health/Psychiatric Substance Misuse Other Medical Other Disability
 Unknown/Undisclosed

Housing Status:

Homeless Own Rent Shelter Other Unknown/Undisclosed

Total Number Living in Household:

1 2 3 4 5 6 7 8 or more Unknown/Undisclosed

Source of Income:

Employment TAFDC SNAP EAEDC SSDI SSI/Pension/Other Retirement Partner/Spouse Support
 Child Support Alimony Unemployment Other None Unknown/Undisclosed

Type of School (Camper):

Worcester Public Schools Other Public School Private/Parochial School Homeschool