

Welcome to Mystic Lake YMCA Camp! We are happy that you have chosen the YMCA of Lansing for your child's summer camp experience. Please read the following information carefully. Please make sure to mail or fax all forms to camp prior to your child's week at camp. This is to help us better prepare to serve your child's needs.

Mystic Lake YMCA Camp's goals and expectations:

- To provide a safe, inviting and open community atmosphere for all campers.
- To ensure highly trained and qualified staff dedicated to being professional positive role models work with your child(ren).
- To help foster friendships between your child and other campers.
- To allow campers to learn and have fun in our exciting progressive activities and traditional camping programs.

Please use our Parent Handbook as a tool to help better prepare your family for your child(s) upcoming camp experience. We look forward to partnering with you in helping to bring your child up strong in spirit, mind and body!

In The Spirit of Mystic,

Ricky Wright, Executive Director

Check list for all camp forms needed to complete registration. All are included on the following pages. Once you have completed all of these camp forms, please mail or fax them back to camp.

- Camper Release Form
- Health History Form
- USDA Form (We need this form signed and returned even if your family does not qualify.)

Mail these forms to:

Mystic Lake Camp
P.O. Box 100
Lake, MI 48632

Or fax these forms to:

1/989-544-2722

If you need help filling out these forms or have questions please contact us:

1/517-827-9653

Express Check In

If you have completed and returned all of your child's forms including the USDA Summer Food Service Form, have all camp balances cleared up and have deposited money in your child's store account, prior to your child's first day of camp, your family will get to use our Express Check In Service on Sunday.

(Please see following pages for forms)

Mystic Lake YMCA Camp
CAMPER PICKUP AND RELEASE INFORMATION
(Please return entire form with other camp forms)

Camper(s) Name(s) _____

Authorization

(Complete & return w/camp forms)

Please print below the name of only those
Persons, including parents, authorized to
pick up your camper (s):

Signature of Parent or Guardian

Date of Pickup _____

If you have questions regarding your camper's pickup call: 517/827-9650 or 517/339-3109

Release

(Complete when camper is picked up)

To pick up the camper(s) your name must
appear on the Authorization list to the left!
Photo ID required at time of pick-up.

Your Signature (sign at pickup)

Date of Pickup _____

Mystic Lake YMCA Camp
CAMPER PICKUP AND RELEASE INFORMATION
(Please return entire form with other camp forms)

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Photo ID required at time of pick-up.

Your Signature (sign at pickup)

Date of Pickup _____

Mystic Lake YMCA Camp
Health History Form

This should be filled in by parents/guardian of minors

Dates Attending _____

Name _____ Birth Date _____ Age _____
Last First Middle

Home Address _____
Street Address City State Zip

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

Name _____

Address _____ Phone _____
Street Address City State Zip

If not available in an emergency notify:

Name _____

Relationship _____ Phone _____

Address _____
Street Address City State Zip

Insurance Information (Please provide a copy of your insurance card)

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

If so, indicate carrier or plan name _____ Group # _____

Carrier Address _____

Name of Insured _____ Relationship to Participant _____

Policy Holder Insurance ID Number _____

Important - This box must be complete for attendance

Permission to Provide Necessary Treatment or Emergency Care: I hereby give permission to the medical personnel selected by the camp director or designated staff member to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director or designated staff member to secure and administer treatment, including hospitalization, for the person named above.

My child and I have reviewed and agree to the camper Behavior Policy found on page 8 of the Mystic Lake Camp Parent Handbook.

Signature of parent or guardian or adult camper/staff _____

Witness _____ Date _____

I also understand and agree to abide by the restrictions placed on my camp activities.

Signature of minor or adult camper/staff _____ Date _____

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

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 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 to 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)

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 may not take during the summer:

Dietary Restrictions

The following restrictions apply to this individual.

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"/>	16. Ever had any back problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear eyeglasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional or mental difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	29. If female, has she had her first period?	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	29. If no, have you discussed with her?	<input type="checkbox"/>	<input type="checkbox"/>

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

Which of the following Has the participant had?

- Measles
- Chicken Pox
- German measles
- Mumps
- Hepatitis

- TB Mantoux Test
- Date of last test _____
- Result: Positive 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)		_____	_____	_____	_____	_____	_____
BCG		_____	_____	_____	_____	_____	_____

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.

Before your child comes to camp, please take a moment to check him/her for head lice. This parasite is very transferable to other children and can pose a real problem at camp.

Name of Family physician _____ Phone _____

Address _____

Name of Family dentist/orthodontist _____ Phone _____

Address _____

Date of Last Physical _____

My child is physically and emotionally able to participate in all camp activities without limitation: Yes No

If "no", please explain activity restrictions: _____

Authorization To Release

Names of persons other than parent to whom child may be released:

1. _____ 3. _____

2. _____ 4. _____

Signature of parent or guardian _____ Date _____

Transportation/Field Trips

I hereby give my permission to Mystic Lake Camp for my child to be transported in a vehicle and/or participate in field trips and for visits to the doctor office, urgent care or emergency room for care.

Signature of parent or guardian _____ Date _____

Special Needs

Does your child have special needs? If yes, what advice can you provide us with in handling your child's special needs?

Please be specific: _____

Parental Tips

What method of working with your child gets the best results from you at home? _____

What should the camp counselor know about your child in working with him/her this summer? _____

Date

Dear Parent or Guardian:

Our organization serves nutritious free meals as part of the federally funded Summer Food Service Program for Children (SFSP). Children are defined by the SFSP as being 18 years of age and under or persons over 18 who are determined by a state or local public educational agency to be mentally or physically disabled. In order to be eligible for these federal funds, we must document the number of enrolled children with household incomes less than or equal to the SFSP family size/income guidelines. With your cooperation, we can qualify for federal reimbursement and keep costs to you at a minimum. Please complete and return this form.

HOW TO APPLY

FOOD STAMP/FIP/FDPIR HOUSEHOLDS: Write the children's names, the Food Stamp, FIP, or FDPIR case numbers for these children, and the signature of an adult household member on the application. If your child(ren) is a member(s) of a Food Stamp, FDPIR, or FIP household, the child(ren) is automatically eligible to receive free meals. If Food Stamp, FIP or FDPIR case numbers are provided, they may be used to verify the current certification for whom free meal benefits are claimed.

FOSTER CHILD: Write the foster child's name, his/her personal income, and the signature of an adult on the application. Each foster child must have their own separate application.

ALL OTHER HOUSEHOLDS: The application must have the camper's name(s) and the names of all household members. List the amount of income each person received last month with the source of each person's income (example: pay, Social Security, child support, unemployment benefits, etc.). The signature and the Social Security number of the person completing the application must be included (or check the box labeled "I do not have a social security number" if that adult does not have a Social Security number).

OTHER INFORMATION

Privacy Act Information: Social Security Number

The Richard B. Russell National 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 meals. The Social Security Number of the adult household member who signs the application is required unless you list a Food Stamp or FIP/FDPIR case number for your child, OR if you are applying for a foster child. You must check the "I do not have a Social Security Number" box if the adult household member signing the application does not have a Social Security Number. We will use your information to see if your child is eligible for free or reduced price meals and for administration and enforcement. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look for violations of program rules. These facts must be told to the household member whose Social Security Number is given. Any other use of the Social Security Number must be specified here.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

Sincerely,

See reverse for Income Chart and Application Instructions.

Application Instructions:

Your children may qualify for free summer meals if your household income falls within the limits on this chart.

Total Family Size	Annual	Monthly	Twice per Month	Every Two Weeks	Weekly
1	\$18,889	\$1,575	\$788	\$727	\$364
2	\$25,327	\$2,111	\$1,056	\$975	\$488
3	\$31,765	\$2,648	\$1,324	\$1,222	\$611
4	\$38,203	\$3,184	\$1,592	\$1,470	\$735
5	\$44,641	\$3,721	\$1,861	\$1,717	\$859
6	\$51,079	\$4,257	\$2,129	\$1,965	\$983
7	\$57,517	\$4,794	\$2,397	\$2,213	\$1,107
8	\$63,955	\$5,330	\$2,665	\$2,460	\$1,230
	\$6,438 *	\$537 *	\$269 *	\$248 *	\$124 *

* For each additional household member add:

If your entire household gets Food Stamps, FIP, or FDIPIA, follow these instructions:

Part 1: Skip this part.

Part 2: Skip this part.

Part 3: List Camper's name, Session Name/Number, check "Yes," and list a case number.

Part 4: Skip this part.

Part 5: Sign and date the form. A Social Security number is not necessary.

Part 7: Answer this question if you choose to.

If you are applying for a homeless, migrant, or runaway child check the appropriate box. Fill out application by following instructions for ALL OTHER HOUSEHOLDS.

If you are applying for a FOSTER CHILD, follow these instructions:

Part 1: Check the box and list the child's personal use monthly income, if any.

Part 2: Skip this part.

Part 3: Use a separate application for each foster child. List the camper's name, and Session Name/Number.

Part 4: Skip this part.

Part 5: Sign and date the form. A Social Security number is not necessary.

Part 6: Answer this question if you choose to.

Part 7: Answer this question if you choose to.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: Skip this part.

Part 2: Check the appropriate box, if any.

Part 3: List each Camper's name, and Session Name/Number.

Part 4: Follow these instructions to report total household income from last month.

Column 1- Names:

- List the first and last name of each person living in your household, related or not (such as grandparents, other relative, or friends). You must include yourself and all children living with you. Attach another sheet of paper if you need to.

Column 2- Gross Incomes:

- Next to each person's first and last name list each type of income received last month. Next to the amount circle how often the person got it (weekly, every other week, twice a month, or monthly).
 - Earning from work:** List the gross income each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions. Net income should ONLY be reported for self-owned business, farm, or rental income.**
 - All other income:** List the amount each person got last month from welfare, child support, and alimony in the second column. List the amount each person got last month from pensions, retirement, and Social Security in the third column. List All Other Income sources in the fourth column. All Other Income includes Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household, and ANY OTHER INCOME.
 - If the person does not have any income circle "No" in the last box.

Part 5: An adult household member must sign and date the form, and list a Social Security Number, or check the box "I do not have a Social Security Number."

Part 6: Skip this part.

Part 7: Answer this question if you choose to.

2008 Summer Food Service Program Free Meals Application

Part 1 - Foster Child YES ****Child's spending money per month \$** _____ If none available, list \$0.
 Use a **SEPARATE application for each FOSTER CHILD**

Part 2 - Homeless **Migrant** **Runaway**
 If the child you are applying for is homeless, migrant, or a runaway check the appropriate box and call the District/School Homeless Liaison or Migrant Coordinator at _____.

Part 3 - The names of all children in the household attending camp or The name of ONE Foster Child attending camp.

Camper's Name	Session Name/Number	Does your child receive Food Stamps/FIP/FDPIR? If "YES," you must list a case number.*	
		<input type="checkbox"/> NO	<input type="checkbox"/> YES _____
		<input type="checkbox"/> NO	<input type="checkbox"/> YES _____
		<input type="checkbox"/> NO	<input type="checkbox"/> YES _____
		<input type="checkbox"/> NO	<input type="checkbox"/> YES _____
		<input type="checkbox"/> NO	<input type="checkbox"/> YES _____
		<input type="checkbox"/> NO	<input type="checkbox"/> YES _____

*If you listed a Food Stamp/FIP/FDPIR case number for EACH child, skip to Part 5.

Part 4- Total Household Gross Income-You must tell us how much and CIRCLE how often it is received.

Name List everyone in the household	Earnings from work (Before taxes)	Welfare, child support, alimony		Pensions, retirement, Social Security		All other income		Circle if NO income
		Weekly	Monthly	Weekly	Monthly	Weekly	Monthly	
<i>Example Jane Doe</i>	\$100	Weekly	Monthly	\$500	Weekly	Monthly		NO
1	\$	Weekly	Monthly	\$	Weekly	Monthly		NO
2	\$	Weekly	Monthly	\$	Weekly	Monthly		NO
3	\$	Weekly	Monthly	\$	Weekly	Monthly		NO
4	\$	Weekly	Monthly	\$	Weekly	Monthly		NO
6	\$	Weekly	Monthly	\$	Weekly	Monthly		NO
6	\$	Weekly	Monthly	\$	Weekly	Monthly		NO
7	\$	Weekly	Monthly	\$	Weekly	Monthly		NO

Part 5 - Signature and Social Security Number (Adult household member must sign.)
 If Part 4 is completed, the adult signing the form must also list his or her Social Security Number or check the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my child may lose meal benefits, and I may be prosecuted.

Sign Here: **Print Name:** _____ **Date:** _____
Adult Social Security Number: _____ I do not have a Social Security Number
Address _____ **City** _____ **Zip Code** _____ **County** _____
Home Phone _____ **Work Phone** _____

Do not fill out this part. This is for school use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12
Household Size: _____ **Total Gross Income:** \$ _____ **Week** _____, **Every 2 Weeks** _____, **Twice a Month** _____, **Month** _____, **Annual** _____
Foster Child: _____ **Categorical Eligibility:** _____ **Eligibility:** Free _____ Reduced _____ Dealt _____
Temporary Free _____ **Time Period:** _____ (expires after _____ days)
Reason for Denial: _____ Income too High _____ Incomplete Application _____ Other (specify) _____
Determining Official's Signature: _____ **Date:** _____ **Date Withdrawn:** _____

Part 6 - Foster Children In most cases foster children are eligible for free meals regardless of your household income.
 Foster Home License Number: _____ (optional)
 A. The welfare agency or court is legally responsible for the child and the foster home is, in fact, and extension of the welfare agency or court.
 B. The child is a resident of a licensed "Group Foster" home or a residential institution.
****Only the foster child's spending money is counted as income on this application. Do not include money from occasional or part-time jobs like paper routes and babysitting. If you have any questions, please contact the school.**

Part 7 - Child's Racial/Ethnic Identity (Optional)
Check one or more racial identities:
 American Indian or Alaskan Native Asian
 Black or African American White
 Native Hawaiian or Other Pacific Islander Other

Check one ethnic identity:
 Hispanic or Latino
 Neither Hispanic nor Latino

Privacy Act Information: Social Security Number
 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 social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Food Stamp Program, 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 will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly
 (In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

<i>Verification - This is for school use only.</i>		
Date Selected for Verification: _____	Sample Selection:	
Response Due from Household: _____	<input type="checkbox"/> Focused	<input type="checkbox"/> Random
Second Notice Sent: _____	<input type="checkbox"/> Basic	
Food Stamp/FIP Eligibility:	Income \$ _____	Verification Results:
<input type="checkbox"/> Not Confirmed	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
Confirmed:	<input type="checkbox"/> Wage Stubs	<input type="checkbox"/> Free to Reduced
<input type="checkbox"/> Food Stamp Office	<input type="checkbox"/> Written Documents	<input type="checkbox"/> Free to Paid
<input type="checkbox"/> Notice of Eligibility	<input type="checkbox"/> Collateral Contact	<input type="checkbox"/> Reduced to Free
<input type="checkbox"/> ATP Card issued monthly	<input type="checkbox"/> Agency Records	<input type="checkbox"/> Reduced to Paid
	<input type="checkbox"/> Other _____	<input type="checkbox"/> No Change
Confirming Official's Signature: _____	Date: _____	Reason For Eligibility Change:
Follow-up Official's Signature: _____	Date: _____	<input type="checkbox"/> Income
		<input type="checkbox"/> Household Size
		<input type="checkbox"/> Refused to Cooperate
Date Adverse Notice Sent: _____		<input type="checkbox"/> Other