Camp Jorn YMCA

2021 Day Camp Req. Forms Packet

For more information regarding Day Camp Registration please call 715-543-8808 or email Office Manager/Registrar Jenn Davis at jenn@campjornymca.org . Please note that all forms are due by May 6th, 2021. Registration will not be considered complete until all required forms are received.

DAY CAMP CHECK LIST

HEALTH HISTORY & EMERGENCY CARE PLAN	
CHILD CARE ENROLLMENT FORM	
DAY CARE IMMUNIZATION RECORD	
TRANSPORTATION PERMISSION FORM IF TAKING AVW SHUTTLE	
SUMMER 2020 TRANSPORTATION REGISTRATION FORM IF TAKING AVW SHUTTLE	
AUTHORIZATION TO ADMINISTER MEDICATION – CHILD CARE CENTERS (ONLY IF YOUR CHILD WILL BE TAKING MEDICATION WHILE AT CAMP)	
SCHOLARSHIP APPLICATION IF APPLYING FOR FINANCIAL AID AND NON-REFUNDABLE $50 DEPOSIT PER CAMPER	

Please mail complete forms to:

Camp Jorn YMCA

ATTN: JENN DAVIS

13591 Zenner Lane

Manitowish Waters, WI 54545

Fax complete forms to:

608-901-0593

Email complete forms to:

Jenn@campjornymca.org

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance

PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child | Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip) | Home / Cell Phone No.

Does child reside at this location? ☐ Yes ☐ No | Place of Employment and Work Phone No.

b. Name and Relationship to Child | Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip) | Home / Cell Phone No.

Does child reside at this location? ☐ Yes ☐ No | Place of Employment and Work Phone No.

AUTHORIZED PERSONS – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off**.** If no one, write "None."

a. Name and Relationship to Child | Home / Cell Phone No.

Email Address Where Reachable While Child is in Care | Place of Employment and Work Phone No.

b. Name and Relationship to Child | Home / Cell Phone No.

Email Address Where Reachable While Child is in Care | Place of Employment and Work Phone No.

EMERGENCY CONTACT – The person to be notified in an emergency when parents / guardians cannot be reached.

☐ Yes ☐ No This person is authorized to pick up the child.

Name and Relationship to Child | Home / Cell Phone No.

Email Address Where Reachable While Child is in Care | Place of Employment and Work Phone No.

PHYSICIAN OR MEDICAL FACILITY

Name	
Address (Street, City, State, Zip Code)	Telephone No.

AUTHORIZATIONS

☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.

☐ Yes ☐ No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.

☐ Yes ☐ No I give permission for my child to participate in ☐ Transported ☐ Walking field trips and other activities during operating hours.

☐ Yes ☐ No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian	Date Signed

Camp Jorn YMCA Immunization Policy

Each year, the American Academy of Pediatrics and the Canadian Pediatric Society publishes a "Recommended Childhood and Adolescent Immunization Schedule." Practicing pediatricians across North America recognize these schedules as the standard of care regarding childhood & adolescent vaccinations. Concurrently, the US Centers for Disease Control & Prevention (CDC) annually publish vaccine standards for adults.

Among our 3 pillars of the YMCA values is the imperative healthy living and social responsibility. We embrace this value specifically by taking preventive measures to protect the public health of our camp community as a whole. Therefore, **Camp Jorn YMCA is requiring that all campers and staff attending camp be immunized as outlined below.**

While parents may choose to defer the vaccination of their children, for Camp Jorn YMCA this is not an issue of individual rights and choice, but an issue of public health and policy. The routine vaccination of all campers and staff is an important public health matter especially in the confined environment of a residential summer camp with round-the-clock communal living where illnesses spread much more easily.

Policy: All those who are attending Camp Jorn YMCA programs are required to have age appropriate vaccines as recommended by the American Academy of Pediatrics (AAP), and the Center for Disease Control (CDC), with the exceptions noted.

• DTaP, DT, Td, or Tdap (Diphtheria,Tetanus and Pertussis)

• Tdap vaccine is now required for children over age 11, booster every 10 years

• IPV (Poliovirus)

• HIB (Haemophilus influenza type b bacteria)

• PCV 13 (Pneumococcal) vaccine

• Hepatitis B

• MMR (Measles, Mumps, Rubella) or serologic evidence of immunity. Adults born before 1957 are assumed to be immune to measles

• Varicella vaccine (Varivax – for Chicken Pox), or serologic or historical evidence of immunity

• Menactra (Meningococcal disease / Meningitis) – required for those age 11 and older

Policy Exceptions: We recognize that individuals who have had a documented allergy or severe adverse reaction to a particular vaccine may not be able to complete the immunization schedule outlined above. Additionally, individuals with medical conditions such as congenital immunodeficiency or HIV, cancer and who are receiving chemotherapy, transplant patients, and persons receiving immunosuppressive drugs and chronic steroids also may not be able to receive certain vaccines. In these extremely rare circumstances, current documentation from a Physician (MD or DO), or a Pediatric/Family Practice Advanced Practice Nurse (ARNP or PNP), describing the reason for exemption from immunization must be furnished to Camp Jorn YMCA. We are happy to discuss case by case management of the extremely rare circumstance of medical contraindication to partial or complete vaccination.

This policy will be enforced in accordance with all applicable local, state, and federal laws. In no way should this policy be interpreted to violate the laws of the State of Wisconsin or regulations affecting licensed Residential/Day Camps within the state.

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (Rev. 09/08)

STATE OF WISCONSIN
ss. 252.04,Wis. Stats.

DAY CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO DAY CARE CENTER . State law requires all children in day care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the day care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the day care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child's day care provider or your local health department.

STEP 1 — PERSONAL DATA — PLEASE PRINT

Child's Name(Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

STEP 2 — IMMUNIZATION HISTORY

List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (4) OR (**X**) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus *Influenzae* Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.
☐ Yes year______________________(Vaccine is not required)
☐ No or Unsure (Vaccine is required)

STEP 3 — REQUIREMENTS

The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at day care entrance. Children who reach a new age/grade level while attending this day care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES						
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B		
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib[1]	3 PCV[2]	2 Hep B	1 MMR[3]	
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib[1]	3 PCV[2]	3 Hep B	1 MMR[3]	1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT [4]	4 Polio			3 Hep B	2 MMR[3]	2 Varicella

[1]If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

[2]If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

[3]MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

[4]Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

STEP 4 — COMPLIANCE DATA AND WAIVERS

IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the day care center), OR

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to day care center).

☐ Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the day care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the day care center may result in court action against the parents and a fine of up to $25.00 per day of violation.

☐ For health reasons this child should not receive the following immunizations___________(List in STEP 2 any immunizations already received)

Physician's Signature Required

☐ For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

☐ For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

STEP 5 — SIGNATURE

To the best of my knowledge this form is complete and accurate.

SIGNATURE - Parent, Guardian or Legal Custodian ____________________ Date Signed ____________________

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

Authorization	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to apply sunscreen to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to apply repellent to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.	Brand Name	Ingredient Strength

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

☐ No specific medical condition
☐ Asthma ☐ Diabetes ☐ Gastrointestinal or feeding concerns including special diet and supplements
☐ Cerebral palsy / motor disorder ☐ Epilepsy / seizure disorder ☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism
☐ Other condition(s) requiring special care – Specify.

☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
☐ Food allergies – Specify food(s).

☐ Non-food allergies – Specify.

2. Triggers that may cause problems –Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian	Date Signed (mm/dd/yyyy)

Review dates: __________ __________ __________ __________ __________

Transportation Permission – Child Care Centers

Use of form: Use of this form is voluntary. However, completion of this form will help ensure compliance with portions of DCF 250.08, DCF 251.08 and DCF 252.09 of the Wisconsin Administrative Codes regarding regularly scheduled, center-provided / center-contracted transportation of children in care to and from the center. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file at the center and update the information as needed. The center shall maintain the completed form in the child's file for the duration of the child's enrollment. Note: A copy of this form shall be carried in the vehicle when transporting the child. If the child has special health care needs, also include a copy of CFS-2345, Health History – Child Care Centers.

A. CHILD INFORMATION

Name	Address – Home (Street, City, State, Zip Code)

☐ Yes ☐ No Does the child have any special health care needs? If "Yes", attach the department form, "Health History – Child Care Centers."

B. PARENT / GUARDIAN INFORMATION Provide information where the parent / guardian may be reached while the child is in care.

	Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
1.				
	Address (Street, City, State, Zip Code)			
2.				
	Address (Street, City, State, Zip Code)			

C. EMERGENCY CONTACT INFORMATION Provide information on the person to contact if the parent / guardian cannot be reached.

Name	Address (Street, City, State, Zip)	Telephone Number

D. AUTHORIZED DESTINATIONS / PERSONS INFORMATION

Address Child Transported From (Street, City)	Address Child Transported To (Street, City)	Person Authorized to Receive Child
1.		
2.		
3.		
4.		

Procedure to follow when parent / guardian or authorized adult is not at destination to receive child – Specify.

E. CHILD'S HEALTH CARE PROVIDER INFORMATION

Name – Physician	Address (Street, City, State, Zip Code)	Telephone Number

F. AUTHORIZATION

1. ☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
2. ☐ Yes ☐ No I hereby give permission for my school-aged child to enter a building unescorted.

SIGNATURE – Parent / Guardian	Date Signed

Camp Jorn YMCA Day Camp

Summer 2021 Transportation Registration Form

All campers utilizing the shuttle must be pre-registered for the bus. The "State of Wisconsin Transportation Permission-Child Care Centers" form must also be filled out and signed by a parent/guardian.

Shuttle Bus Service Bus service is available from Arbor Vitae-Woodruff Elementary School (AV-W).

Please see the Day Camp Parent Packet for additional information.

Please indicate each day your camper requires transportation below with an "X"

DAY CAMP SESSION	Monday	Tuesday	Wednes-day	Thursday	Friday	Weekly total
Session 1: June 7-11						$________
Session 2: June 14-18						$________
Session 3: June 21-25						$________
Session 4: June 28-July 2						$________
Session 5: July 5-9						$________
Session 6: July 12-16						$________
Session 7: July 19-23						$________
Session 8: July 26-30						$________
Session 9: August 2-6						$________
Session 10: August 9-13						$________
Session 11: August 16-20						$________
Session 12: August 23-27						$________

☐	Please check the box if applicable: I would like transportation to/from Camp Jorn from the AVW School Shuttle	Camper Name: ________________	BUS TOTAL: $________ $6 per day/ per camper

AUTHORIZATION TO ADMINISTER MEDICATION – CHILD CARE CENTERS
INSTRUCTIONS FOR USE

Use of form: This form is mandatory for family child care centers to comply with DCF 250.07(6)(f)1.a. Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers, day camps and certified providers; however, completion of this form meets the requirements of DCF 251.07(6)(f)1.a., DCF 252.44(6)(e)1.a. and DCF 202.08(4)(f) and 202.09(5)(c)., Wis. Admin. Codes. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: When a parent is requesting that the provider administer prescription or non-prescription medication to a child in care, this form shall be completed and signed by the parent or guardian before any medication is administered. A separate form shall be used for each medication. Place the form in child's file when medication is no longer required / authorized. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

CERTIFIED CHILD CARE CENTERS:
This form is voluntary for certified providers; however, completion of Page 1 *Medication Information and Authorization* and Page 2 *Documentation of Medication Administration – Certified Child Care Providers* meets the requirements of DCF 202.08(4)(f) and 202.09(5)(c)., Wis. Admin. Codes.

Have the child's parent or guardian complete and sign Page 1 *Medication Information and Authorization*. Record administration of the authorized medication in the spaces provided on Page *2 Documentation of Medication Administration – Certified Child Care Providers*. Lines should not be skipped.

LICENSED FAMILY CHILD CARE CENTERS:
Page 1 *Medication Information and Authorization* is mandatory for family child care centers to comply with DCF 250.07(6)(f)1.a. Failure to comply may result in issuance of a noncompliance statement.

Have the child's parent or guardian complete and sign Page 1 *Medication Information and Authorization*.

Page 2 *Documentation of Medication Administration – Certified Child Care Providers*, is only for use by certified child care providers. It is not used by Family Child Care Centers because medication administration must be documented in the center medical log book on the day that the medication is administered.

Log the dates and times medication was administered in the center medical log book. Blanket authorizations that exceed the length of time specified on the label are prohibited; no medication intended for use by a child in the care of the center may be kept at the center without a current medication administration authorization from the parent. For more information, see the document *Directions for Use of Center Medication & Injury Log or Logs* available from the Child Care Information Center website as part of the Appendix J Resource List.

LICENSED GROUP CHILD CARE AND DAY CAMPS:
Page 1 *Medication Information and Authorization* is voluntary for group child care centers and day camps; however, completion of this form meets the requirements of DCF 251.07(6)(f)1.a. and DCF 252.44(6)(e)1.a., Wis. Admin. Codes.

Have the child's parent or guardian complete and sign Page 1 *Medication Information and Authorization*.

Page 2 *Documentation of Medication Administration – Certified Child Care Providers*, is only for use by certified child care providers. It is not used by Group Child Care Centers because medication administration must be documented in the center medical log book on the day that the medication is administered.

Log the dates and times medication was administered in the center medical log book. Blanket authorizations that exceed the length of time specified on the label are prohibited; no medication intended for use by a child in the care of the center may be kept at the center without a current medication administration authorization from the parent. For more information, see the document *Directions for Use of Center Medication & Injury Log or Logs* available from the Child Care Information Center website as part of the Appendix J Resource List.

AUTHORIZATION TO ADMINISTER MEDICATION – CHILD CARE CENTERS
MEDICATION INFORMATION AND AUTHORIZATION

A. FACILITY AND CHILD INFORMATION

Name – Child Care Center

Name – Child	Birthdate (mm/dd/yyyy)

B. MEDICATION INFORMATION: Medication shall be in the original container and labeled with the child's name. The label shall include dosage and directions for administration.

Name – Medication	Dosage	Time(s) of Day to be Administered	How to be Administered	Dates – Medication Time Period	
				From	To
		☐ AM ☐ PM			
		☐ AM ☐ PM			
		☐ AM ☐ PM			
		☐ AM ☐ PM			

☐ Yes ☐ No **Does the over-the-counter (OTC) medication label indicate the child's physician should be consulted?** If "Yes" I have consulted with my child's physician, and I am authorizing a dosage consistent with the physician's recommendation.

Name – OTC Medication ______________ Parent Initials ______________

Additional information / special instructions / contraindications – Specify.

C. AUTHORIZATION

I hereby authorize administration of the above medication to my child by staff of the child care center listed above.

SIGNATURE – Parent or Guardian	Date Signed

AUTHORIZATION TO ADMINISTER MEDICATION – CHILD CARE CENTERS
DOCUMENTATION OF MEDICATION ADMINISTRATION – CERTIFIED CHILD CARE PROVIDERS

Instructions: This section is to be completed only by **certified child care providers** to document the actual administration of the medication. Lines should not be skipped.

	Date Administered	Time Administered	Dosage	Signature / Initials of Person Who Administered the Medication
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
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21.				
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29.				
30.				

A LETTER FROM OUR CEO

Dear Camp Jorn Family and Friends,

Thank you for considering a Camp Jorn experience! Together at Camp Jorn YMCA, we make a positive difference for our community through our childcare, day camp and resident camp programs. We are committed to making each one of these programs accessible to all who would like to participate.

Camp Jorn counts on the generosity of our alumni, fellow community members and volunteers to raise funds to help us keep our fees affordable! We know sometimes, families do need extra help, and we plan for that as well.

Our Y provides quality, affordable childcare to more than 25 children, giving them a safe and enriching start to learning while mom and dad are at work. We provide a safe environment for children to learn, grow and develop social-emotional, cognitive and physical skills, so that parents can go to work knowing your kids are with trained professionals who care about their development and well-being.

Through our summer day and resident camps, we also provide a fun and safe community for children and teens to explore new environments, build confidence through accomplishments, make lasting friends and memories, so they can grow as individuals and leaders.

We hope that you join us and if needed, please use the funds that we have raised, to help to make these life changing experiences affordable. We are committed to making sure each person and family feels welcome and supported!

Warmly,
Dennis Lipp
CEO

CAMP JORN YMCA SCHOLARSHIP GUIDELINES AND APPLICATION

Camper scholarships are available to assist families who need financial help. A scholarship provides funding for camp fees for campers with a proven need.

Camp Jorn YMCA is committed to making our camping experience available and affordable to all children and families without regard to sex, ethnic origin, religious affiliation, or socio-economic level. Scholarship dollars are received through many sources. We are grateful for the generosity of all our sponsors.

GUIDELINES:

For **Res camp,** scholarships range between 20% & 75% of the base rate of one session only. For **Day camp,** scholarships are assessed for the duration of care, as long as funds are available. For **Child Care,** scholarships are assessed for the duration of care, as long as funds are available. Bussing may also be covered by scholarships.

- Please submit this application with a registration form, along with the nonrefundable $50 deposit.
- Please make sure to complete all sections.
- Confidentiality will always be maintained.
- Upon receipt of both forms, your application will be reviewed, and you **will** be notified of your allocation via phone or email.
- It is the responsibility of the parent/guardian to pay all costs in excess of the benefits available from the scholarship before the session starts.
- If you have any questions or concerns, please contact the camp office at 715-543-8808 or Jenn@campjornymca.org
- We do require parents to assist their camper in writing a thank you letter to our sponsors upon return from camp. A few lines of how they enjoyed camp, what activities they did and what it means to them will be greatly appreciated. The letters are forwarded to the sponsors.

Please note that your Scholarship Application will not be reviewed without first submitting a Day Camp Application and a $50 nonrefundable deposit per camper. You can make this payment by calling our Registrar, Jenn Davis, with a credit card number at 715-543-8808 or by sending a check to camp:

Camp Jorn YMCA
Attn: Jenn Davis
13591 ZENNER LANE
MANITOWISH WATERS WI 54545

Camp Jorn YMCA Scholarship
2021 Application
(Only one form per family is needed)

Campers Name: ________________________________Date of Birth: ________

(Last Name, First Name)

List Additional Siblings: ____

List Additional Siblings: ____

(Please mark an asterisk* by any sibling planning on attending camp)

Parent/Guarding Applying: ____

(Last Name, First Name)

Email Address:____

Spouse/Partners Name: ____

I am applying for: ☐ Child Care ☐Day Camp ☐Resident Camp

ESTIMATED 2021 FAMILY INCOME (Check One)
(Include a/J unearned Income. Examples: SSDI, SSP, Food stamps Child support, student loans, WIC, Pensions, TANF, Soc.* Sec, *Unemployment)

	$0-$14,999
	$15,000 -$19,999
	$20,000 · $29,999
	$30,000 · $39,999
	$40,000 • $49,999
	$50,000 · $69,999
	$70,000 +

Financial Statement:

Last years gross family income before taxes: _________________________

What is your family's monthly income? ______________________________

What is your family's total monthly expenses? _______________________

Is your camper a participant in their schools free or reduced lunch program? ☐Yes ☐ No

If you selected YES, please attach copy of lunch letter.

Proof of your current financial situation- Please check all items that you are supplying. You must include copies for your application to be processed. Please provide one item from the list below to prove income:

☐Copy of your 2020 Federal Tax Form **☐Two recent paystubs**

☐Copy of Medicaid Card (front & back copy) **☐Copy of free/reduced lunch letter**

☐Other: Please describe:

____

____

Have you ever received a Camp Jorn YMCA scholarship previously?

☐Yes ☐No

If yes, in what years? How did you hear about your scholarship program?

Please list all financial circumstances that you would like to have considered as a basis for awarding this scholarship:

Is there anything else you would like us to know?

******Attach pages or write on back if you need more space to write your answers.**

Estimate amount that you can contribute.

I can contribute approximately $________________ towards my capers total balance. (Please do not leave this bank. We need to how much you can afford to contribute.)

VERIFICATION STATEMENT: I certify that all information provided to Camp Jorn YMCA on this camper scholarship application is true. I understand that providing false information will make me ineligible for participation in Camp Jorn YMCA programs at a reduced fee. The YMCA reserves the right to refuse assistance to any applicant

Signature of parent/guardian **Date**