



RIVERSIDE

Wellness & Fitness Center Peninsula

Dear Parent(s):

Welcome to the RWFC Fit Camp. In order to better prepare you and your child/ren, we ask that you take some time to go over the following material enclosed in this packet.

The following forms must be turned in at the time of registration, or we will not accept your registration:

- PHYSICAL EXAMINATION FORMS
- IMMUNIZATIONS that are up to date
- A copy of a BIRTH CERTIFICATE

A registration form will not be accepted if there are any lines left blank. If something does not apply, please, write N/A.

Included in this packet, is a Weeks Attending Form, please, fill out the weeks your child will be attending. If you need to add a week or cancel a week, proper notification to the Fit Camp staff must be made 2 weeks prior. If your child is signed up for a week, and does not attend without notification, you will be charged for the whole week.

Please, feel free to call at 875-7525 if you have any questions concerning the camp or the materials enclosed. Thank you for selecting Riverside Wellness and Fitness Center!

Sincerely,
Fit Camp Staff

Caitlin Wilcox
Youth Programs Manager
Caitlin.Wilcox@rivhs.com

Fit Camp

What to bring to camp:

- . Tennis Shoes (Open toed shoes are not allowed)
 - . Bathing Suit
 - . Towel
- . Lunch (name must be on lunch box)
 - . Two snacks
 - . Water bottle (must be labeled)
 - . Sunscreen (must be labeled)
- . Medications (with proper documentation)



SUMMER CAMP APPLICATION FOR ENROLLMENT

Please, fill out every line. No lines should be left blank.

Wellness & Fitness Center
Peninsula

FIRST DAY OF ENROLLMENT

CHILD'S NAME

FIRST

MIDDLE

LAST

MONTH DAY YEAR

NAME YOU PREFER YOUR CHILD TO BE CALLED:

CHILD'S
ADDRESS

STREET

CITY

STATE

ZIP

☐

MALE

☐

FEMALE

CHILD'S DATE OF BIRTH

PREVIOUS CHILD DAY CARE PROGRAMS AND SCHOOLS ATTENDED: _____

CURRENT GRADE LEVEL _____

Please, fill in the necessary information for each parent, as it is a requirement of the licensing standards of the state of Virginia. Do not leave any spaces blank. If it does not apply, write N/A.

MOTHER/
GUARDIAN

FIRST

MIDDLE

LAST

ADDRESS _____ HOME PHONE (____) _____ - _____

CELL (____) _____

DATE OF BIRTH

EMPLOYED BY: _____ OFFICE (____) _____ - _____

MONTH DAY YEAR

WORK ADDRESS: _____ WORK HOURS _____

EMAIL ADDRESS: _____

FATHER/
GUARDIAN

FIRST

MIDDLE

LAST

ADDRESS _____ HOME PHONE (____) _____

DATE OF BIRTH

EMPLOYED BY: _____ OFFICE (____) _____

CELL (____) _____

MONTH DAY YEAR

WORK ADDRESS: _____ WORK HOURS _____

EMAIL ADDRESS: _____

Please, indicate the priority in which we should call, in the case of an emergency. _____

EMERGENCY INFORMATION:

Emergency contacts other than parent or doctor (legal authorities will be contacted for children left at the Center one hour after closing time of Fit Camp.) **You must list 2 contacts, with local addresses. Do not leave any line blank.**

1) Name _____ Phone _____

Address _____

2) Name _____ Phone _____

Address _____

Consideration is given to the individual needs of every child and the ability of the program to meet those needs. Please, inform the staff before camp begins, if your child requires any special accommodations. This information enables the staff to better meet the needs of your child, within available resources and to the reasonable extent.

My child has the following allergies and/or intolerances, and action to be taken in case of emergency:

Chronic physical problems, pertinent developmental information and special accommodations needed:

Please, list any important information about your child that would best help our staff on a typical day. For example, what helps when your child is angry or upset. The more information you can provide for us, the better resources we have to meets the needs of your child:

Pediatrician/Family Physician: _____ Phone Number: _____

Current Medications: _____

Name (s) of person (s) authorized to pick up child:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Name (s) of person (s) NOT authorized to pick up child (MUST HAVE LEGAL DOCUMENTATION):

- 1) _____
- 2) _____
- 3) _____

Signature of Parent/Guardian **Date**

AGREEMENTS

1. The Fit Camp/Wellness Center agrees to notify the parent/guardian whenever the child becomes ill and the parent/guardian will arrange to have the child picked up as soon as possible if so requested by the center.
2. The parent/guardian will inform Fit Camp/Wellness Center within 24 hours if the child or any member of the household has developed a communicable disease. Any life threatening disease must be reported immediately.
3. The parent/guardian authorizes the Fit Camp/ Wellness Center to obtain immediate medical care if any emergency occurs while the child is in our care.*
4. Camp fees may be paid at the Members Services Desk (s) at any time during facility hours. Payments are due the Friday before the week attending. Or complete the Child Care Payment form, and payment will be taken out on Friday at 12pm.
5. I agree to pay an UNAUTHORIZED LATE PICK-UP FEE, per child each 15 minute period (\$20), or subsequent portion therefore the child(ren) is left in the center after the time of close.
6. This parent agreement is subject to change in whole or in part by Riverside Wellness and Fitness Center upon two weeks notice
7. I understand that there must be an Authorization to Administer Medication, signed & on file for the staff to administer medication to the child. Medication must be labeled with child's name for it to be administered as well.

SIGNATURES

Parent or Guardian

Date

Administrator of Camp

Date

Year Child Attended Camp: _____

* If there is an objection to seeking medical care, a statement should be obtained from the parent/guardian that states their objection and the reason for their objection.

OFFICE USE ONLY IDENTITY VERIFICATION

Proof of the child's identity and age may include a certified copy of the child's birth certificate, birth registration card, notification of birth (hospital, physician or midwife record), passport, copy of the placement agreement or other proof of child's identity from a child placing agency, record from a public school in Virginia, or certification by a principal or his designee of a public school in the U.S. that a certified copy of the child's birth record was previously presented. Viewing the child's proof of identity is not necessary when the child attends a public school in Virginia and the center assumes responsibility for the child directly from the school (i.e. after school program) or the center transfers responsibility of the child directly to the school (i.e. before school program). While programs are not required to keep the proof of the child's identity, documentation of viewing this information must be maintained for each child.

Place of Birth	Birth Date	Birth Certificate Number	Date Issued
Other Form of Proof			

Swimming Ability

In order to ensure complete safety while your child/ren are at RWFC Fit Camp we would like to know your thoughts on your child/ren's swimming ability. Do you think that they are advanced enough to swim on their own (with supervision of course)? Do they feel comfortable in the water? Do you they need assistance from floatation type devices such as water wings? Do they need someone with them? Please include anything that you would like us to know. For your child's safety, it is important for us to find out the level that your child may be at currently or any skills they may already possess. If you do not want your child to use the pool please mark that below also.

Thank You.

Child's Name: _____ **Age:** _____

Signature of Parent/Guardian

Date



**Authorization Form for
Non-prescription Over-the-Counter Skin Products
Licensed Child Day Centers
VDSS Division of Licensing Programs Model Form**

INSTRUCTIONS:

This form must be completed by the parent/guardian to authorize the use of:

Sunscreen
Diaper ointment or cream
Insect repellent

_____ has my permission to apply the
(Name of Provider)

non-prescription over-the-counter (OTC) skin product listed below to my child,

_____. (Child's name)

Product Name:

Known Adverse Reactions (if any):

All OTC products must:

Be in the original container and, if provided by the parent, labeled with the child's name
Be used according to manufacturer's recommendation and instructions for application
Not be used beyond the expiration date of the product

Sunscreen:

Must have a minimum sunburn protection factor (SPF) of 15
Shall be inaccessible to children under 5 yrs. & children in therapeutic or special needs programs
Children nine yrs. and older may self administer sunscreen if supervised

Diaper ointment/cream and Insect repellents:

Shall be kept inaccessible to children
Record of use shall be kept that includes child's name, date, frequency of application, and any adverse reactions

This authorization is effective from: _____ until: _____
(Start date) (End date)

Parent's Signature: _____ Date: _____



GENERAL PHOTO RELEASE
(Please complete one form for each person)

Adult 18 and over

I hereby give Riverside Health System, and/or _____, its agents, and/or assignees permission to use the photograph(s)/film taken of me in any manner it deems proper. I relinquish all rights, title, and interest I may have in the finished pictures, negatives, and copies for this purpose. I waive the right of prior approval and hereby release Riverside Health System from any and all claims for damages of any and all kinds based on this use of said material. I am of legal age and freely sign this release, which I have read and understand.

(Signature)

Under 18

I hereby give Riverside Health System, and/or _____, its agents, and/or assignees permission to use the photograph(s)/film taken of the minor named below for the purpose of _____. I relinquish all rights, title, and interest I may have in the finished pictures, negatives, and copies for this purpose. I waive the right of prior approval and hereby release Riverside Health System from any and all claims for damages of any and all kinds based on this use of said material. I am of legal age and have the right to contract for this minor, and freely sign this release, which I have read and understand.

✱

(Signature of parent or guardian)

✱

(Name of minor)

Please complete the following for all patients:

(Print Patients Name)

(Date of Birth)

(Address)

(Room # if applicable)

(Riverside Facility)

(Witness)

(Date)

(Photographer)



RIVERSIDE

Wellness and Fitness Center
Peninsula

Weekly sessions · June 21st—August 20th

Ages 3-12

- Complete separate forms for each child. Pre-registration required.
- Check the desired camp weeks in the bottom section of the form.
- PAYMENT for each week is DUE IN FULL on FRIDAY or return completed payment form and payment will be taken out on Friday at 12pm.

Participant's Name: _____ Age: _____ Birth date: ____/____/____ Sex: _____

Fit Camp: RWFC Members and RHS Employees - \$110.00 · Nonmembers - \$150.00
\$5 off for the 2nd child. (Week rate only)

We are offering a day rate of \$25 per day.

Dates	Weeks Attending (Please check)	Total Due	Date Paid
June 21st—June 25th			
June 28th—July 2nd			
July 5th—July 9th			
July 12th—July 16th			
July 19th—July 23rd			
July 26th—July 30th			
August 2nd—August 6th			
August 9th—August 13th			
August 16th—August 20th			
Tentatively August 23rd—August 27th			

Riverside Wellness & Fitness Centers Childcare Payment Authorization Form

Thank you for choosing the Riverside Wellness & Fitness Center for your childcare needs. Please fill out your child's information below:

Child's Name: _____ DOB: ____/____/____

Child's Name: _____ DOB: ____/____/____

Below are two options to choose from regarding payment for childcare services. Please note a few important pieces of information:

1. Childcare payments are due every Friday by 12:00 pm for the current week. If you are paying by check or cash, please do so at the front desk. All parents who opt to have their payments deducted to the card provided will be charged each Friday before COB.
2. If your payment is not made on Friday by 12:00 pm, you will be unable to bring your children back for childcare services until your balance is paid in full.
3. If you have any questions or concerns regarding your payment, contact Caitlin Wilcox at: Caitlin.Wilcox@rivhs.com

I would like to pay for childcare services by:

☐ Check ☐ Credit Card ☐ Cash

I hereby authorize the Riverside Wellness & Fitness Center to deduct my weekly childcare dues each Friday before 12:00 pm using the following information:

Credit Card # _____ Expiration Date: _____

☐ Visa ☐ MasterCard | ☐ Discover ☐ American Express

Name (please print)

____/____/____
Date

Signature