

Gately Youth Center

“Summer Arts Program” Application Form

Child’s last name

Child’s first name

Date of Birth

Home Address (this is the address to
which we will direct all camp mailings)

Name of School

City

Zip Code

Home Phone:

Please check one option

___ June 26 – August 11
(8:30am. - 3:30pm.) Cost: \$50.00 per week

___ June 26 – August 11
(8:30am. - 6:00pm.) Cost: \$65.00 per week

Note: a \$65.00 non-refundable deposit is required along with the application form.
Please make check or money order payable to “Cambridge Youth Programs”

Parent/Guardian Name

Parent/Guardian Name

Home Address

Home Address

Home Telephone #

Home Telephone #

Place of Work

Place of Work

Work Telephone

Work Telephone

Emergency Contact: Name

Daytime Telephone #

Gately Youth Center "Summer Arts Program" Release Form

Child's name: _____

Parent/Guardian's name: _____

1. I hereby give my child permission to participate in all program activities and trips:

Parent/Guardian's name: _____ Date: _____

2. I hereby give permission for authorized staff to take my child to the nearest hospital for emergency treatment. (If an injury occurs within Cambridge, the program will transport your child to Cambridge City Hospital or Mount Auburn Hospital, depending on which is nearest the scene of the accident. Outside of Cambridge, we will go to the nearest hospital.) I also authorize staff to apply first aid and sunscreen when necessary.

Parent/Guardian's name: _____ Date: _____

3. I give permission to the City of Cambridge and Gately Youth Center to use photographic and video reproductions of my child for publicity purposes.

Parent/Guardian's name: _____ Date: _____

4. My child has permission to walk home from the program after 3:30pm.

Parent/Guardian's name: _____ Date: _____

5. The following individuals may pick up my child from the program. If someone other than these people picks up my child, I will notify staff in writing in advance.

Name: _____ Telephone#: _____

Address: _____ Relationship: _____

Name: _____ Telephone#: _____

Address: _____ Relationship: _____

Name: _____ Telephone#: _____

Address: _____ Relationship: _____

Parent/Guardian's name: _____ Date: _____

**Gately Youth Center
DHSP, 51 Inman Street
Cambridge, MA 02139**

HEALTH FORM

THIS FORM MUST BE COMPLETED AND SIGNED BY A PHYSICIAN AND RETURNED BEFORE THE FIRST DAY OF THE SUMMER PROGRAM. ALL INFORMATION IS KEPT CONFIDENTIAL.

Name of child: _____

Parent/Guardian #1: _____ Home Phone: _____

Parent/Guardian #2: _____ Home Phone: _____

Physician's Name: _____ Office Phone: _____

Health Care Coverage:

Harvard Pilgrim Health Plan ____ ID Number _____

Blue Cross/Blue Shield ____ ID Number _____

Medicaid ____ ID Number _____

Other plan (name): _____ ID Number _____

Is the child currently taking medication? If so, what is it, how often must it be taken, and why is it being administered? _____

Does the child have any allergies? If so, please describe: _____

Is a physician, the staff at a guidance facility, or any other health care professional, currently seeing this child? If so, by whom and for what reasons? _____

Has this child received a CORE evaluation? _____

Does this child have any unusual fears or special needs we should be aware of? _____

PLEASE INDICATE DATES, NOT CHECK MARKS, FOR THE FOLLOWING IMMUNIZATIONS:

Diphtheria Petruasis	Original Series	#1	#2	#3		

Tetanus (DPT)	Boosters DR after age 6	#1	#2	#3	#4	#5
Polio	For each immunization, please indicate type:		OVP-T	Trivalent oral		
			OVP-1=S=S	Salk, etc.		
List dates:	#1	#2	#3	#4	#5	#6
Measles	Had natural infection ____					
Rubella	Live vaccine (Swartz or Edmondston) ____					
Mumps	Killed vaccine ____					

Other immunization: _____

I hereby certify that the child named above has been examined on _____
 And that he/she is in good physical condition and is capable of participating in all camp activities.

 Physician's signature

 Date

I hereby give permission for authorized staff to take my child to the nearest hospital for emergency treatment. Program staff will transport children to either Cambridge Hospital or Mount Auburn Hospital, depending on proximity, if injury occurs within Cambridge.

 Parent/Guardian's signature

 Date

This form must be completed and returned before your child may attend the Summer Arts Program.

Please return this form to:

**Gately Youth Center
 51 Inman Street
 Cambridge, MA 02139**

FAMILY INFORMATION QUESTIONNAIRE

This form provides staff with a brief picture of your child and his/her family. The following information is strictly confidential and will only be used to help the staff understand and learn about your child.

Any further information you feel might help the staff members make your child more comfortable at the program can be added on a separate sheet.

Parent's Name: _____ Work phone: _____

Child's Name: _____ Nickname: _____

Birthdate: _____ Telephone #: _____

Address: _____ Zip Code: _____

What language do you speak at home? _____

Can your child speak and understand English? _____

How many children are in your family? _____

Name: _____ Sex: _____ Date of Birth: _____

Others in family who live in the same house:

_____ Sex: _____ Relationship: _____

_____ Sex: _____ Relationship: _____

What do you hope your child gains from this program?

What would you like to gain as a parent?

Does your child have any special needs? (health, physical, emotional)

Yes ___ No ___ If yes, what type? _____

Have there been any major changes in your family routine during the past year? A new baby? Moving? Accident or injury to your child or other family member? _____

How does your child usually respond to a new experience? Shy? Assertive? Please describe: _____

What do you find most effective in calming your child when he/she is upset? _____

What activities does your child like best? Favorite toys/games/songs/activities? _____

What activities does your child seem to like least? _____

Are there any special dietary concerns and/or restrictions (e.g. foods not allowed, etc.)? _____

What additional aspects of your child's physical and/or emotional development would you like our staff to know about? _____

Please describe your child's schedule on a typical day: _____

Additional comments: _____

Parent's Signature: _____

Date: _____

**CITY OF CAMBRIDGE
DEPARTMENT OF HUMAN SERVICE PROGRAMS
FINANCIAL ASSISTANCE FORM**

WE ASK EVERYONE WHO POSSIBLY CAN TO PAY THE FULL AMOUNT SO THAT WE CAN CONTINUE TO OFFER FINANCIAL AID TO THOSE WHO NEED IT MOST. ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL.

Name of Child: _____ Home Phone: _____
 Address: _____ City: _____ Zip Code: _____
 Parent Name: _____ Home Phone: _____
 Address: _____ Work Phone: _____
 Parent Name: _____ Home Phone: _____
 Address: _____ Work Phone: _____

Please list everyone living in the home (primary residence), including parent(s):

1. _____ AGE: _____
2. _____ AGE: _____
3. _____ AGE: _____
4. _____ AGE: _____
5. _____ AGE: _____
6. _____ AGE: _____

You may be asked for documentation of the answers below. Please be sure to include all sources of income to your household.

	Weekly	or	Monthly
Child Support	_____		_____
Alimony	_____		_____
Gross Pay, Wage earner #1	_____		_____
Gross Pay, Wage earner #2	_____		_____
Gross Pay, Wage earner #3	_____		_____
Unemployment Benefits	_____		_____
AFDC	_____		_____
Rental Income	_____		_____
Other Income	_____		_____
TOTAL INCOME	_____		_____

Are there any special financial issues you would like us to take into consideration? _____

To the best of my knowledge the above information is correct

Signature: _____ Date: _____