# Team Randy Application 2024

*Please scan and email applications to:*
teamrandy1985@gmail.com
*Or mail to*: Team Randy, Inc.
213 Rt 37E (K-Mart Shopping Ctr)
Toms River, NJ 08753

"LIVE LIFE WITH NO EXCUSES!"

| First Name | Last Name | Middle Initial |
|---|---|---|
| | | |

| Date of Birth | Grade (Fall 2023) | T-Shirt Size |
|---|---|---|
| | | |

| Home Address | Phone numbers |
|---|---|
| | cell: |
| | home: |
| | work: |

| Emergency Contact Information: | |
|---|---|
| Name: | cell: |
| relation: | work: |
| name: | cell: |
| relation: | work: |

| Photo Release |
|---|
| *I agree that Team Randy may use photographs of my child with or without his/her name and for any lawful purpose including, but not limited to: illustration, advertising, social media, and/or web content.* |
| Parent/Guardian Signature: |
| Date: |

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| Medical Information | |
|---|---|
| Physician's Name: | phone: |
| Preferred Hospital: | |
| Special Needs: | Special Education Classification: |
| Recent Injuries/Surgeries: | Allergies:: |
| Medications that would need to be administered during camp: Please list times administered) | |
| | |

| Consent for Medical |
|---|
| *State law requires parents to sign the statement (only exception being religious beliefs). If you do not sign this statement, on the basis of religion, a separate waiver form must be signed.* <br> *"I the parent/guardian of the above named child, give permission to the physician selected by Team Randy to secure proper treatment in the event of an emergency."* |
| Parent/Guardian Signature: |
| Date: |

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| Please fill out this form providing any information that will help us to best support your child and establish the framework for a FUN FILLED successful summer! Information you provide will allow us to be proactive and encourage positive interactions while avoiding conflict. |
|---|
| Can your child swim?: |
| Describe how special needs/medication may affect his/her day. |
| Does your child have any mental health or emotional diagnosis? If yes, describe how this may affect his/her day. |
| Does your child have any allergies? (Please list seasonal and/or food, etc.) |
| Does your child have any specific fears that we should be aware of? (i.e. dogs, heights, water, darkness, etc.) |
| Anything else we should know? |

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| Medication Distribution Form | | |
|---|---|---|
| Camper's First Name | Last Name | Middle Initial |
| | | |

| Home Phone Number | |
|---|---|
| Cell Phone Number | |
| Email Address | |

| Medication | Dosage | Times administered |
|---|---|---|
| | | |
| Medication | Dosage | Times administered |
| | | |

| Consent for Medication Distribution |
|---|
| *"I, the parent/guardian of the child listed above, authorize the designated Team Randy staff person to administer the above medication(s) to my child."* |
| Parent/Guardian Signature: |
| Date: |

New Jersey Department of Health and Senior Services

# STANDARD SCHOOL / CHILD CARE CENTER IMMUNIZATION RECORD

| NAME OF CHILD (Last, First, MI) | DATE OF BIRTH (Mo./Day/Yr.) | SEX ☐ M ☐ F |
|---|---|---|
| NAME OF PARENT/GUARDIAN | TELEPHONE NUMBER(S) | |
| ADDRESS | | |
| ADDRESS | IMMUNIZATION REGISTRY NUMBER | |

| VACCINE TYPE | 1ST DOSE MO/DAY/YR | 2ND DOSE MO/DAY/YR | 3RD DOSE MO/DAY/YR | 4TH DOSE MO/DAY/YR | 5TH DOSE MO/DAY/YR | LEAD SCREENING *(Not Required)* | |
|---|---|---|---|---|---|---|---|
| | | | | | | TEST DATE | RESULT |
| DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (if Td or DT[1] Indicate in corner box) | | | | | | | |
| POLIO-INACTIVATED POLIO VACCINE (IPV) (if oral vaccine, indicate OPV in corner box) | | | | | | | |
| MEASLES, MUMPS, RUBELLA (MMR) | | | | | [5] Document below single antigen vaccine receipt, serology titers, or Varicella disease history | | |
| HAEMOPHILUS B (HIB) [2] | | | | | | | |
| HEPATITIS B [3] | | | | | Hepatitis B | DATE: | TITER: |
| VARICELLA [4] | | | | | Varicella | DATE: | TITER: |
| PNEUMOCOCCAL CONJUGATE [2] | | | | | Measles | DATE: | TITER: |
| INFLUENZA [6] | | | | | Mumps | DATE: | TITER: |
| OTHER, SPECIFY: | | | | | Rubella | DATE: | TITER: |

☐ Provisional Admission Attached - Date Granted:_______________ ☐ Medical Exemption Attached ☐ Religious Exemption Attached

(1) REQUIRES MEDICAL EXEMPTION
(2) REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (2 Months - 5th Birthday Only)
(3) REQUIRED FOR K-GRADE 1 (whichever is first). GRADE 6 BEGINNING 9-1-01, AND GRADES 9-12, EFFECTIVE 9-1-04
(4) REQUIRED FOR DAY/CHILD CARE ENROLLED (19 Months and older) AND GRADE K-GRADE 1 (whichever is first) EFFECTIVE 9-1-04
(5) MMR single antigen receipt requries MO/DAY/YR, serologies require titers, and varicella disease history requires MO/YR.
(6) REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (6 Months - 59 Months)

IMM-8
OCT 08