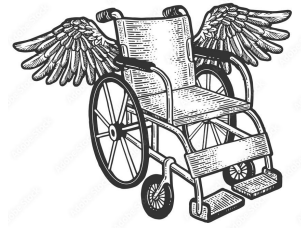


Team Randy Application 2024

"LIVE LIFE WITH NO EXCUSES!"



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

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>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.</i>
Parent/Guardian Signature:
Date:

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!"



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
<p><i>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.</i></p> <p><i>"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."</i></p>
Parent/Guardian Signature:
Date:

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!"



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.)

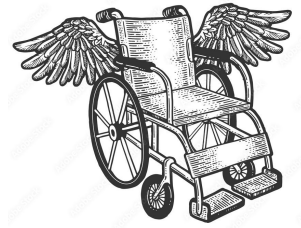
Does your child have any specific fears that we should be aware of? (i.e. dogs, heights, water, darkness, etc.)

Anything else we should know?

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!"



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		
<p><i>"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."</i></p>		
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 <input type="checkbox"/> M <input type="checkbox"/> F					
NAME OF PARENT/GUARDIAN							
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)	
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (if Td or DT ⁽¹⁾ Indicate in corner box)						TEST DATE	RESULT
POLIO-INACTIVATED POLIO VACCINE (IPV) (if oral vaccine, indicate OPV in corner box)							
MEASLES, MUMPS, RUBELLA (MMR)							
HAEMOPHILUS B (HIB) ⁽²⁾							
HEPATITIS B ⁽³⁾						DATE:	TITER:
VARICELLA ⁽⁴⁾						DATE:	TITER:
PNEUMOCOCCAL CONJUGATE ⁽²⁾						DATE:	TITER:
INFLUENZA ⁽⁶⁾						DATE:	TITER:
OTHER, SPECIFY:						DATE:	TITER:
<input type="checkbox"/> Provisional Admission Attached - Date Granted: _____ <input type="checkbox"/> Medical Exemption Attached <input type="checkbox"/> Religious Exemption Attached							
<p>(1) REQUIRES MEDICAL EXEMPTION</p> <p>(2) REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (2 Months - 5th Birthday Only)</p> <p>(3) REQUIRED FOR K-GRADE 1 (whichever is first). GRADE 6 BEGINNING 9-1-01, AND GRADES 9-12, EFFECTIVE 9-1-04</p> <p>(4) REQUIRED FOR DAY/CHILD CARE ENROLLED (19 Months and older) AND GRADE K-GRADE 1 (whichever is first) EFFECTIVE 9-1-04</p> <p>(5) MMR single antigen receipt requires MO/DAY/YR, serologies require titers, and varicella disease history requires MO/YR.</p> <p>(6) REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (6 Months - 59 Months)</p>							
IMM-8 OCT 08							