2024 SESSION REGISTRATION

Cost $129 per week, per camper.

$79 when enrolled in full time Camp Universal the same week

Payment in full due at time of registration.
Space is limited. First come, first serve.

Please Complete One Form Per Camper

SELECT YOUR CAMP(S)

☐ **Sports Performance**
June 17-21
9am-12pm

☐ **Soccer**
July 8-12
9am-12pm

☐ **Basketball**
July 29-August 2
9am-12pm

Camper Last Name: ____________________

Camper First Name: ____________________

D.O.B: ____________

Universal Member: Yes No

Parent Name (Print): ____________________

Address: ____________________

Email: ____________________

Home Phone: ____________________

Cell Phone: ____________________

Internal Use:

Method of Payment

☐ Check # ________

☐ Credit Card

☐ Cash

Paid $: ________

Date: ________

2323 Oregon Pike · Lancaster · 717-569-5396
www.UniversalAthleticClub.com

MODEL
RELEASE

RELEASE TO USE PICTURES

In consideration of my participation in programs at Universal Athletic Club, Inc. ("Universal"), I hereby give Universal, its legal representatives and assigns and those acting with its permission, the right to copyright and/or use, reuse and/or publish and republish pictures of me in any advertising, promotion or public relations involving Universal and its facilities. Due to printing, photographing and reproduction techniques, my image may be distorted in character or form and I do not object to this.

I hereby waive any right to inspect or approve the finished picture, advertising copy or other matter that may be used in conjunction with pictures of me.

I hereby release, discharge and agree to save Universal, its representatives, assigns, employees or any person acting with its permission, from and against any liability as a result of any distortion, alteration or use in composite form of my picture.

I have read this Release and I fully understand the contents of it.

Signature: ______________________________

For a Minor:

I hereby certify that I am the parent and/or guardian of ______________________ a minor under the age of twenty one years. In consideration of value received, the receipt of which is hereby acknowledged, I hereby consent to use by Universal (as set forth above) of any pictures of such minor which have been or are taken.

Guardian's signature : ______________________________

Address: ______________________________

____

Date: ______________________________

2323 Oregon Pike, Lancaster, PA 17601
717-569-5396
www.UniversalAthleticClub.com

CHILD HEALTH APPRAISAL

CHILD DAY CARE CENTERS– GROUP DAY CARE HOMES -FAMILY DAY CARE HOMES

DATE OF EXAM

CHILD'S NAME : LAST, FIRST, MIDDLE	BIRTHDATE
CHILD ADDRESS	TELEPHONE NUMBER

1. REVIEW OF HEALTH HISTORY	2. MEDICAL INFO. PERTINENT TO DIAG. AND TREATMENT IN CASE OF EMERGENCY
3. SPECIAL INSTRUCTIONS TO PROVIDER REGARDING ANY MEDICATION REQUIRED DURING DAY CARE HOURS	4. RECOMMENDED MODIFICATIONS OR LIMITATIONS OF CHILD'S ACTIVITIES OR DIET (ALLERGIES, ETC.)

5. VISION (ACUITY)	6. HEARING (AUDITORY)	7. GROWTH MEASUREMENT
☐ NORMAL ☐ ABNOR-	SUBJECTIVE SCREENING DATE __________ AUDITORY DATE __________	Ht.______' ______ PERCENTILE WT. _______ LBS. _______ PERCENTILE CIRC. ______-_____

10. DENTAL SCREENING	YES	NO	9. MEDICAL	NORMAL	ABNOR-		NORMAL	ABNOR-	10. HGB
CARIES			EARS/NOSE			ABDOMEN			HGB ☐ NORMAL ☐ ABNORMAL
MISSING PERMANENT TEETH			EYES			GENITALIA/ BREASTS			GM OR HTC ☐ NORMAL ☐ ABNORMAL
ORAL INFECTION			MOUTH/			EXTREMITIES/JOINTS			%
PROTRUSIONS			LUNGS			SPINE			11. BLOOD PRESSURE /
			CARDIOVASCULAR			SKIN/ LYMPH			☐ NORMAL ☐ ABNORMAL

12. DEVELOPMENTAL APPRAISAL
IS CHILD PROGRESSING NORMALLY WITH AGE OR GROUP? ☐ YES ☐ NO

DENVER DEVELOPMENTAL ☐ YES ☐ NO

13. IMMUNIZATIONS

DTP: DIPHTHERIA-TETANUS-PARESIS	DATE	TRIVALENT ORAL POLIO VACCINE	DATE	OTHER:	DATE
1ST 12 MONTHS		1ST 12 MONTHS		MEASLES (15 MONTHS OR OLDER)	
2ND 14 MONTHS		2ND 14 MONTHS		MUMPS (15 MONTHS OR OLDER)	
3RD 18 MONTHS		3RD 18 MONTHS		RUBELLA (15 MONTHS OR OLDER)	
BOOSTER		4TH (4-8 YEARS)		HIS HOMOPHILES (18 MONTHS)	
BOOSTER		URINALYSIS		TUBERCULOSIS TEST	

14. RECOMMENDED FURTHER MEDICAL TESTS OR EXAMINATION ON THE FOLLOWING:

☐ VISION ☐ GROWTH ☐ HBG ☐ HEAD CIRCUMFERENCE ☐ HEARING ☐ DENTAL ☐ BLOOD PRESSURE

☐ MEDICAL (SPECIFY)

☐ DEVELOPMENTAL PROGRESS (SPECIFY)

☐ IMMUNIZATION (SPECIFY)

PRINTED NAME OF PHYSICIAN	TELEPHONE NO.
PHYSICIAN'S ADDRESS	

____
PHYSICIAN'S SIGNATURE

____
DATE