Office Use Only
- □ Complete Application
- □ Registration Paid
- □ Tuition Paid
- □ ProCare Account set up

Special Group Request:

Application and Registration Form

Camper's Name: _____ Date of Birth: _____

Camper's Address: _____

Grade entering in Fall 2024: _____ T-shirt Size (Child SMLXL or Adult SML): _____

Parent/Guardian Name: _____ E-mail address: _____

Parent/Guardian Name: _____E-mail address: _____

Check List:

- ☐ Completed Online Registration
- ☐ Paid Registration Fee + First Weeks Tuition
- ☐ Downloaded and Completed Enrollment Packet
- ☐ Signed all required forms
- ☐ Turned in all forms to Adventure Park Childcare

Return completed forms:

Email: info@apusachildcare.com Fax: 301-865-8918

Mail: 11113 W. Baldwin Road
Monrovia, MD 21770

Child's Schedule: *Please check off the appropriate schedule for your child on a weekly basis*

Registration Fee: $75.00/ per child annually

☐ 5 Full Days ($290) 9:00am-4:00pm

☐ 3 Full Days ($235) *9:00am-4:00pm*

☐ **Extended Care**

☐ AM $50/week ☐ PM $50/week ☐ Both $80/week

Camper Emergency Information Form

This form must be completed and returned to us with application.

Child's Name: _____

Camp Attending (Weeks): _____

Parent/Guardian Name: _____

Parent/Guardian Address: _____

_____

When the parent cannot be reached, please list alternate emergency contacts:

1 Name (Last)_____ (First)_____

Telephone (daytime) _____

Cell _____

2 Name (Last)_____ (First)_____

Telephone (daytime) _____

Cell _____

3 Name (Last)_____ (First)_____

Telephone (daytime)_____

Cell _____

In emergencies requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your Signature authorizes our staff at the camp facility to have your child transported to the hospital.

Parent Signature: _____Date _____

Camper Health History

The following information is required:

Child's Name: _____

Current residence: _____

Emergency Contact
(Parent or Legal Guardian): _____ Phone: _____

2nd Emergency Contact
(Other than Parent Above): _____ Phone: _____

Primary Care physician _____ Phone: _____

HEALTH INFORMATION:

Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐ NO

☐ YES, Explain:

_____

_____

_____

Are there any medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's camp experience is positive? ☐ NO

☐ YES, Explain:

_____

_____

_____

IMMUNIZATION INFORMATION:
Must list current residence above

For campers who currently reside within the United States, a Unites state territory, or the District of Columbia: Does the camper have any immunization exemptions because of a parental or guardian objection or medical contraindication? ☐ NO

☐ YES, List:

_____

For campers who reside outside the United States, a United States territory, or the District of Columbia: Attach record of vaccination or immunity on Department form MDH-896.

_____

Parent or Legal Guardian's Signature Date

CATION POLICIES AND AGREEMENT

Child's Name: _____

How to apply: To reserve your child's spot the nonrefundable registration fee of $75.00- and one-weeks tuition is needed for each camper, along with a **COMPLETED AND SIGNED APPLICATION, CAMPER MEDICAL RECORD FORM, CAMPER EMERGENCY INFORMATION FORM, AND SITE PERMISSION SLIP FOR ATTRACTIONS, AND MEDICATION FORM**. If you need additional application and forms, please go to www.adventureparkacademy.com

Where to apply: You can find all enrollment forms available on our website. Payment must be submitted at the time of registration.

Tuition Policies: Cash, Credit Card or Tuition Express may be used to make your camp payment. The weekly tuition is due each Monday for the current week. Siblings receive a discount of 10% off the oldest child's tuition. **If payment is not received your child may be dis-enrolled from camp.**

Refund Policies: We are very flexible and allow registration changes on a case-by-case basis. However, after June 1st parents/guardians will be responsible for tuition for the weeks they registered for. Cancellations will result in forfeiture of your registration fee and the weekly tuition will still be due.

T-shirt Policy: All campers will receive one camp adventure camp shirt

CONTRACTUAL AGREEMENT

I understand the tuition obligation and wish to enroll my child/children for the summer of 2024 at Adventure Park USA. I acknowledge that no cancellations can be made after June 1, 2023. I also understand that no enrollment changes will be accepted 2 weeks prior to the start of summer camp. Furthermore, withdrawal of my child 2 weeks prior to the start of the camp week will result in a forfeiture of my registration and first week deposit or weekly tuition. In addition, I shall be responsible for any attorney or collection fees required to collect unpaid tuition and/or any other outstanding camp charges, which may include t-shirt, change, or cancellation fee. By signing this agreement, I also give my permission for my child/children to be transported to away activities by bus or Adventure Park USA vehicles. I understand that photographs may be taken for promotional usage. Weeks and dates are subject to change depending on the Frederick County Public school calendar.

_____

Parent or Guardian Signature

_____

Please Print Name **Date:**

Weekly Payment Options: Tuition is due every Monday for the week. Late fee of $30 will be assessed if payment is not received by COB Monday of the current week.

Please check which method of payment you will be using each week. ***No Checks accepted.***

Tuition Express_☐_ (automated weekly payment credit or debit) Form located at end of packet.
Credit Card _☐_

Please fill out the below permission slip

My child _____ has permission to participate in the following activities if my child meets safety requirements.

☐ Go-Karts	☐ Laser Tag	☐ Climbing Wall	☐ Zipline
☐ Ropes Course	☐ Arcade	☐ Roller Coaster(s)	☐ Water slides
☐ Amusement Rides	☐ Scrambler	☐ Tilt-a-whirl	☐ Spin Zone
☐ Bouncing pillow			

Parents Authorization

The health history is correct as far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me. In the event I cannot be reached for emergency, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child. I further authorize the camp director or his designee to provide over-the-counter medication to my child in case of necessity (_____Initial)

As part of the overall Adventure Park USA Childcare, participants may be photographed and videotaped. I hereby grant permission and approval that my child may be photographed or videotaped by Adventure Park USA staff and that the participant's likeness, name, performance, artwork or written work may be used by Adventure Park USA in any Adventure Park USA publications, materials, advertisements, website and programs (_____Initial)

I understand that my child's participation in some of Adventure Park USA childcares activities is potentially hazardous. My child is voluntarily participating in the Childcare. I am aware of the potential risks of the activities checked above and I hold harmless Adventure Park USA, its agents, employees, representatives, and all others from any and all responsibilities or liability for injuries or damages, except those caused by the negligent act or omission of any of the foregoing persons or entities, arising out of, resulting from or in connection with the participants use of the Adventure Park USA's facility.
(_____Initial)

By signing below, I agree that I have received and read an Adventure Park USA handbook. I further agree to follow the policies, procedures, and practices placed before me within the Adventure Park USA Handbook.

_____ _____

Parent Signature Date

2025 SUMMER CAMP
JUNE 9TH - AUGUST 15TH

AP LEARNING CENTER

JUNE	1 WELCOME TO THE WILD WEST	9	10	11	12	13
	2 WHISTLESTOP 100	16	17	18	19	20
	3 COLOR WARS!	23	24	25	26	27
	4 PARTY IN THE USA	30	1	2	3	4
JULY	5 BEACH WEEK	7	8	9	10	11
	6 SPIRIT WEEK	14	15	16	17	18
	7 MISSION IMPOSSIBLE	21	22	23	24	25
AUGUST	8 ANIMAL PLANET	28	29	30	31	1
	9 TBD	4	5	6	7	8
	10 TBD	11	12	13	14	15

Sunscreen Consent Form

Child's Name: _____
Date of birth:_____
Type of Sunscreen provided:
_____

As a parent/guardian of the above child, I recognize that too much exposure to UV rays may increase my child's risk of getting skin cancer someday. Therefore, I give permission for the staff at Adventure Park USA to **HELP** apply a sunscreen to my child daily. **Staff will only assist with sunscreen if the camper has asked for HELP**. I also understand that I must apply sunscreen to my child before arriving to camp each day. Camp staff will **HELP** reapply sunscreen prior to any outside activities occurring after 12:00pm to all exposed areas of the body except sensitive areas such as eyelids. All sunscreen must be labeled with your child's first and last name with a permanent marker.

I understand **ALL** information regarding the use of sunscreen and my child while in the care of Adventure Park USA Summer camp.

Parent/Guardians Name:_____
Parent/Guardians Signature: _____
Date: _____

Hop aboard the Tuition Express and never write a check again!

As your childcare provider, we are excited to offer you the convenience of automatic tuition payments through Tuition Express. You'll no longer need to write a check or remember your checkbook when you're picking up your child at the end of a hectic day. Your payment will be safely and securely processed by Tuition Express, giving you peace of mind that your tuition has been paid on time! It's easy to enroll and even easier to participate. You'll be joining tens of thousands of parents nationwide who enjoy the ease and convenience of Tuition Express.

To learn more about Tuition Express, automatic payment notifications or reviewing your payment history, please visit www.tuitionexpress.com.

For Bank Account Authorization, complete and return to center management.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION

I (we) hereby authorize _____ , (called "CENTER" in this Authorization) to initiate debit entries to my (our) Checking or Savings Account indicated below at the depository financial institution indicated below (called "DEPOSITORY" in this Authorization). I (we) authorize CENTER to withdraw sufficient funds to pay my (our) regular childcare tuition and/or other childcare related fees that are due and payable. I (we) authorize CENTER to use the third party sender, Tuition Express* to process all payments. I (we) acknowledge that the origination of Automated Clearing House (ACH) transactions to my (our) account must comply with the provisions of United States Law.

Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments.

Your Name _____ Phone # _____ DEPOSITORY - Bank or Credit Union Name _____

Address _____ Bank or Credit Union Address _____

City _____ State Zip City _____ State Zip

Type: [ ] Checking [ ] Savings

Routing Transit Number (see sample below) _____ **Account Number** (see sample below) _____

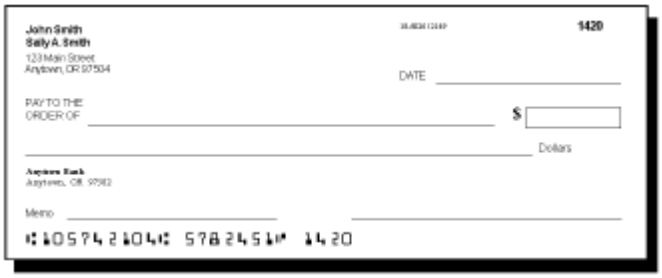
This authorization will remain in full force and effect until I (we) notify the CENTER in writing of its termination in such time and in such manner as to afford Tuition Express and DEPOSITORY a reasonable opportunity to act upon it. Notices must be received at a minimum of 5 business days in advance of the termination date.

_____

Signature Date

Record Retention Notice: The child care provider shall retain all parent (client) authorization forms in a secure location for a period of two years from the date of client withdrawal from the Tuition Express™ program.

*Tuition Express is an assumed business name of Blum Investment Group, Inc.



Routing Number | Account Number | Check Number

Please attach a copy of a voided check here. Deposit slips not accepted.

For Credit Card Authorization, complete and return to center management.

CREDIT CARD PAYMENT AUTHORIZATION

I (we) hereby authorize _____ (called "CENTER" in this Authorization) to initiate recurring credit card charges to the below referenced credit card account for the purpose of collecting childcare related payments. I (we) understand that the charges to the below referenced credit card account will be based on charges that are due and payable at the time of the credit card transaction. I (we) understand that this agreement is between myself (us) and the below referenced "CENTER". I (we) authorize CENTER to utilize Tuition Express* to capture, create, and transmit all credit card information. I (we) indemnify and hold harmless, Tuition Express from any and all liability resulting from any and all transactions. All disputes will be directed to and addressed by and between CENTER and the below signed cardholder. **I (we) understand that to properly affect the cancellation of this agreement, I (we) are required to give CENTER written notice of revocation. A minimum of 5 business days is required to affect revocation.**

PLEASE CONTACT CENTER REPRESENTATIVES FOR CREDIT CARD TYPES ACCEPTED BY CENTER.

_____ _____
Cardholder Name | Phone #

_____ _____
Cardholder Billing Address | Account Number

_____ _____
City | State | Zip | Expiration Date

_____ _____
Cardholder Signature | Date

*Tuition Express is an assumed business name of Blum Investment Group, Inc.

For Official Use Only:

Date Received: _____

Employee Signature: _____

Record Retention Notice: The child care provider shall retain all parent (client) authorization forms in a secure location for a period of two years from the date of client withdrawal from the Tuition Express™ program.

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

STUDENT/SELF NAME: _____
LAST FIRST MI

STUDENT/SELF ADDRESS: _____ CITY: _____ ZIP: _____

SEX: MALE ☐ FEMALE ☐ OTHER ☐ BIRTH DATE: _____/_____/_____

COUNTY: _____ SCHOOL: _____ GRADE: _____

FOR MINORS UNDER 18:

PARENT/GUARDIAN NAME: _____ PHONE #: _____

#	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr	
1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	_____	DOSE #1	DOSE #6
2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2		DOSE #2	DOSE #7
3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	DOSE #3	DOSE #8
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4				_____	_____	_____	_____	DOSE #4	DOSE #9
5	DOSE #5			DOSE #5					_____		_____	_____	DOSE #5	DOSE #10

To the best of my knowledge, the vaccines listed above were administered as indicated.

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

Clinic / Office Name
Office Address/ Phone Number

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age-appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)