



ERNEST D. DAVIS  
Mayor

CAMILLE BANKS-LEE  
Executive Director

DIANE M. TOTINO  
Deputy Director

YOUTH BUREAU CITY OF MOUNT VERNON  
CITY HALL  
ONE ROOSEVELT SQUARE  
MOUNT VERNON, NEW YORK 10550  
(914) 665-2344 - (914) 665- 2346  
FAX: (914) 665-1373

May 8, 2006

Dear Parents and Guardians:

The Youth Bureau would like to welcome the children and parents to the Safe Haven Summer Program. Program participants must be between the ages of 7-12 as of January 2006 to attend. Attached you will find a complete registration package, all of which must be completed prior to enrolling in this program.

You must provide proof of residence, (i.e. utility bill/driver's license, etc.), your child's birth certificate, a medical **including proof of child's inoculations**, completed by your physician, within the school year, (September 2005 – June 2006) or a recent camp medical.

The fee for the six-week program is \$300. This fee includes two T-Shirts, crafts, games, all field trips and admission fees. **The fee is non-refundable. Only cash payment or money order made payable to the Mount Vernon Youth Bureau will be accepted.**

The program will be located at Graham Elementary School, 421 East 5<sup>th</sup> Street, and will begin Wednesday, July 5, 2006 and end Friday, August 11, 2006. The program will be operational Monday through Friday from 9:00 a.m. – 3:00 p.m. Please do not drop-off your child prior to 8:50 a.m., as the Youth Bureau will not be responsible for your child before that time. We do not provide transportation to and from the program site, therefore; your child must be picked-up by 3:00 p.m. If your child is not picked up on time on two or more occasions, we will terminate him/her from the program and give the next child on the list an opportunity to attend.

In addition, if your child presents a behavior problem, they will be discharged from the program immediately.

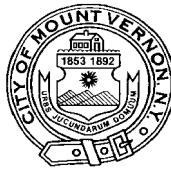
The Mount Vernon Youth Bureau prides itself on the safety of all participants and we respectfully request the full cooperation of the parents. If you have any questions regarding our program, please contact the Youth Bureau at 665-2344.

Thank you for your cooperation.

Sincerely,

CAMILLE BANKS-LEE  
Executive Director

*“A City that Believes”*



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**PROGRAM REGISTRATION & RELEASE FORM**

FACILITY NAME: Graham Elementary School

PROGRAM TITLE: Safe Haven Summer Program

Participant Name: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: MOUNT VERNON State: NEW YORK Zip: 1055\_\_\_\_\_

Age: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Telephone # \_\_\_\_\_ Work Tel. Number: ( ) \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Emergency Contact Phone # \_\_\_\_\_

Doctor to be called in Emergency: \_\_\_\_\_

NAME

PHONE #

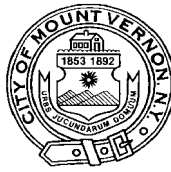
Ethnicity: White: \_\_\_\_\_ Black: \_\_\_\_\_ Hispanic: \_\_\_\_\_ Am. Ind.: \_\_\_\_\_ Asian: \_\_\_\_\_ Other: \_\_\_\_\_

**\*\*ARE YOU RECEIVING PUBLIC ASSI STANCE?** \_\_\_\_\_  
Yes No

**\*\*YOU MUST ANSWER THIS QUESTION IN ORDER FOR YOUR CHILD TO PARTICIPATE IN THIS PROGRAM.**

I do hereby grant my child permission to participate in all activities and agree not to hold the City of Mount Vernon, its officers, employees and agents from any and all loss and liability for injury or results of any injury received by my child during regular program participation. I further agree that my child was examined by a qualified physician and found to be in good health and able to participate in all program activities.

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_ DATE: \_\_\_\_\_



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**SAFE HAVEN SUMMER PROGRAM  
RELEASE & EMERGENCY MEDICAL INFORMATION FOR FIELD TRIP**

DATE: \_\_\_\_\_ DESTINATION: \_\_\_\_\_

RE: \_\_\_\_\_ AGE: \_\_\_\_\_  
Minor

**MEDICAL:**

1. Does your child take daily medication? \_\_\_\_\_ No \_\_\_\_\_ Yes or any, as needed, medication for a medical problem? Please explain: \_\_\_\_\_
2. Drug, food or insect allergies: \_\_\_\_\_  
Please explain: \_\_\_\_\_
3. Will your child be bringing any medication? \_\_\_\_\_  
Name of medication: \_\_\_\_\_ Purpose \_\_\_\_\_
4. Has your child had a tetanus shot? \_\_\_ No \_\_\_\_\_ Yes Date \_\_\_\_\_

In case of injury, I hereby authorize chaperones, in their discretion, to take my child to a doctor or hospital for emergency treatment or whatever service is deemed necessary.

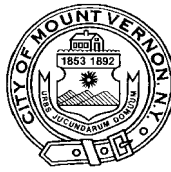
In the event that the minor, \_\_\_\_\_, causes any bodily injury or property damage by his or her negligence, the parent and/or legal guardian agrees to indemnify and hold harmless the City of Mount Vernon and Mount Vernon Library, its officers, agents and employees from any loss or expense arising out of the negligence of the minor.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Father or Legal Guardian

\_\_\_\_\_  
Minor (Name)

\_\_\_\_\_  
Mother or Legal Guardian



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**SAFE HAVEN SUMMER PROGRAM**  
**PHYSICIAN'S HEALTH CERTIFICATE**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

AGE \_\_\_\_\_ DOB \_\_\_\_\_ WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_

Physical Examination reveals the following defects (leave blank if normal):

EYES \_\_\_\_\_ HERNIA \_\_\_\_\_ EARS \_\_\_\_\_  
GENITO URINARY \_\_\_\_\_ LYMPH NODES \_\_\_\_\_ ORTHOPEDIC \_\_\_\_\_  
THYROID \_\_\_\_\_ SKIN \_\_\_\_\_ NOSE \_\_\_\_\_  
EPILEPSY \_\_\_\_\_ TONSILS \_\_\_\_\_ TEETH \_\_\_\_\_  
NERVOUS SYSTEM \_\_\_\_\_ SPEECH \_\_\_\_\_ HEART \_\_\_\_\_  
NUTRITION \_\_\_\_\_ LUNGS \_\_\_\_\_ OTHER \_\_\_\_\_  
Diabetes \_\_\_ Epilepsy \_\_\_ ADD/ADHD \_\_\_ Handicap \_\_\_ Operations \_\_\_ Injury \_\_\_ Other \_\_\_  
Explain \_\_\_\_\_

Is your child currently taking medication for this condition (i.e. ventolin, abuterol, Ritalin, etc.)? If yes please list medication(s) your child is currently taking \_\_\_\_\_

Does your child take this medication in the \_\_\_\_\_ a.m. \_\_\_\_\_ afternoon \_\_\_\_\_ p.m.

General Physical and Emotional Status \_\_\_\_\_

Scoliosis Screening Negative \_\_\_\_\_ Positive \_\_\_\_\_ follow-up \_\_\_\_\_

**Dates of immunizations (Physician, please fill out completely)**

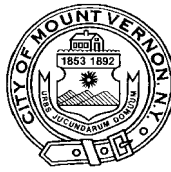
Chickenpox \_\_\_\_\_ Diphtheria \_\_\_\_\_ Smallpox \_\_\_\_\_  
Oral Polio \_\_\_\_\_ Pertussis \_\_\_\_\_ Measles \_\_\_\_\_  
Tetanus Toxioid \_\_\_\_\_ Rubella \_\_\_\_\_ Mumps \_\_\_\_\_

**Tuberculin: Reaction & Date** \_\_\_\_\_

I hereby certify that I have examined the above named child and find that he/she is \_\_\_\_\_ or is not \_\_\_\_\_, physically qualified to attend the Mount Vernon Youth Bureau's Summer Camp and Study Center.

Signed: \_\_\_\_\_ M.D. Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_



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**FIELD TRIP PERMISSION SLIP**

CHILD'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

HOME PHONE NO. \_\_\_\_\_

EMERGENCY CONTACT PERSON \_\_\_\_\_

EMERGENCY PHONE NO. \_\_\_\_\_

NAME OF PROGRAM CHILD ATTENDS: \_\_\_\_\_

DESTINATION: \_\_\_\_\_

TIME OF DEPARTURE:

ANTICIPATED RETURN TIME:

NAME OF CHAPERONE (S)

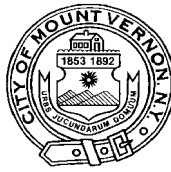
I, \_\_\_\_\_, hereby give consent for my son/daughter \_\_\_\_\_ to attend this field trip sponsored by the Mount Vernon Youth Bureau. I further understand and agree that I am aware that the Mount Vernon Youth Bureau and the City of Mount Vernon are not responsible for any injuries or accidents, which may occur due to my child's negligence. I further understand and agree that the Mount Vernon Youth Bureau and the City of Mount Vernon are not responsible for any physical or emotional disorder, which I failed to mention. I understand that there **will not** be any administering of medication given to my child for any ailment that he/she might have.

**CHECK THE FOLLOWING**

DAILY MEDICATION NEEDED? YES \_\_\_\_\_ NO \_\_\_\_\_  
ANY ALLERGIES? YES \_\_\_\_\_ NO \_\_\_\_\_  
GLASSES/HEARING DEVICE? YES \_\_\_\_\_ NO \_\_\_\_\_

If the answer is yes, please state special needs \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



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**PERMISSION TO SIGN-OUT CHILD**

I, \_\_\_\_\_, HEREBY GIVE PERMISSION FOR  
MY CHILD, \_\_\_\_\_, TO BE PICKED UP BY \_\_\_\_\_  
\_\_\_\_\_ AT THE MOUNT VERNON YOUTH BUREAU'S SAFE  
HAVEN PROGRAM LOCATED AT GRAHAM ELEMENTARY SCHOOL. I  
UNDERSTAND MY CHILD MUST BE PICKED-UP AT 6:30 P.M. SHARP. I ALSO  
UNDERSTAND THAT IF MY CHILD IS NOT PICKED UP ON TIME FOR TWO OR  
MORE DAYS, HE/SHE WILL BE DROPPED FROM THE ROSTER AND WILL BE  
REPLACED WITH A CHILD ON THE WAITING LIST.

\_\_\_\_\_  
PARENT OR GURADIAN

\_\_\_\_\_  
DATE



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### PHOTO/VIDEO RELEASE FORM

I, \_\_\_\_\_ HEREBY GIVE  
(PARENT/GUARDIAN'S NAME)

PERMISSION FOR MY CHILD \_\_\_\_\_, TO BE  
(NAME)

PHOTOGRAPHED/VIEOED. HIS/HER PHOTOGRAPH OR VIDEO MAY BE  
USED FOR PUBLICITY PURPOSES BY THE MOUNT VERNON YOUTH BUREAU.

\_\_\_\_\_  
PARENT/GUARDIAN'S SIGNATURE

DATE \_\_\_\_\_