Las Américas ASPIRA Academy
Summer Camp 2025

Let the team at ASPIRA engage your child this summer!
Our summer program will run from June 9 – August 8, 2025, and it is open to all students' ages 5 through 13! Our developmentally appropriate enrichment activities will focus on scientific inquiry, arts and crafts, and physical activity.

Full Day 9:00 am – 4:00 pm
Breakfast (8:30-8:50 am) and Lunch (12:00-12:30 pm) **included**

Extended Day Care - Available upon request
Before Care 7:00 am - 9:00 am **After Care** 4:00 pm – 5:30 pm

REGISTRATION INFORMATION

Requirements:

- Submit completed registration forms (submit via email or in person at Main Office or Pond View).
- Child Information Card
- Child's current health appraisal (physical within past 12 months) with physician signature and immunization record must be turned in with summer camp registration. Please email to Aspira.summercamp@laaa.k12.de.us
- All of child's school accounts must be current to be eligible for summer camp participation.

After the registration requirements are met, you will receive an email, or text, indicating registration confirmation or additional information needed or waiting list options if space is full (whichever is applicable). Space is not confirmed for any child until ALL five (5) requirements are met.

Refund Policy:

Refund must be requested in writing before April 30, 2025. All refunds will be subject to an $80 non-refundable fee.
No refunds, or changes after May 1, 2025.
Email Aspira.SummerCamp@laaa.k12.de.us with any questions.

2025 SUMMER CAMP REGISTRATION FORM

Student Information

Student Name: _____

Nickname child prefers: _____ ☐ Male ☐ Female

Date of Birth:_____/____/_____ Grade student entering August 2025: _____

Street Address: _____

City: _____ Zip Code: _____ Home Phone#: _____

Parent/Guardian Information

Name of Parent/Guardian #1: _____

Date of Birth:_____/____/_____ **Authorized to Pick-up:** ☐ Yes ☐ No

Email Address: _____

Primary Phone#: _____ Text: ☐ Yes ☐ No

Alternate Phone#: _____ Text: ☐ Yes ☐ No

Name of Parent/Guardian #2: _____

Date of Birth:_____/____/_____ **Authorized to Pick-up:** ☐ Yes ☐ No

Email Address: _____

Primary Phone#: _____ Text: ☐ Yes ☐ No

Alternate Phone#: _____ Text: ☐ Yes ☐ No

Is there a custody or visitation arrangement? ☐ Yes ☐ No

If yes, please email supporting documentation to Aspira.SummerCamp@laaa.k12.de.us

Child Release Information

The following people are authorized to pick up my child from the summer program:

NAME	PHONE#	NAME	PHONE#
1.		4.	
2.		5.	
3.		6.	

I give ASPIRA Academy permission to release my child as indicated. I understand any changes to this information must be submitted in writing to the Main Office. In the event there is a question about who my child is to go home with, my child will be kept at school, I will be notified and I will be responsible for picking him/her up from school.

Signature of Parent/Guardian: _____Date: _____

Emergency Information

If parent/guardian is not available in an emergency, please notify:

Name	Primary#	Alternate#	Relationship to Child
Name	Primary#	Alternate#	Relationship to Child

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the program coordinator to transport, hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

Signature: _____ Date: _____

Family Physician: _____ Phone#: _____

Special medical information, medications, allergies, diet: _____

_____

Family Medical/Hospital Insurance/HMO: _____

Insurance Policy#: _____ Group#: _____ Carrier: _____

Medical Information

Does your child have allergies to medicine, food, latex or insect bites? _____

What Happens: _____Treatment:_____

Indicate student's serious medical conditions: _____

Regular Medications: _____

I give permission for my child to have the following medication according to the medication label.

_____Yes_____No	Orajel/Anbesol	_____Yes_____No	Tylenol (acetaminophen)
_____Yes_____No	Advil/Motrin (ibuprofen)	_____Yes_____No	Bactine Spray to clean "boo-boos"
_____Yes_____No	Caladryl Clear (itch)	_____Yes_____No	First Aid Antiseptic Burn cream
_____Yes_____No	Antacids (ex. Tums)	_____Yes_____No	Benadryl (Diphenhydramine)
_____Yes_____No	Cough drops	_____Yes_____No	Hydrocortisone cream/ointment (itch)

Parent/Guardian Signature:_____Date_____

The school has adopted the following procedures that will normally be followed in caring for your child when he/she becomes sick or injured at school. In extreme emergencies, the school will seek immediate medical care. **In case of emergency and/or need of medical or hospital care the school will call EMS (911) for transport to the nearest medical facility:**

1. The school will contact the Parents/Guardians utilizing available listed on the emergency card.
2. The school will call the other telephone number(s) listed.
3. Based upon the medical judgement of the attending physician, the student may be admitted to a local medical facility.
4. The school will continue to call the parents or guardians until one is reached.
5. The school will continue to call the parents, guardians, or physician until one is reached.

If I cannot be reached and the school authorities have followed the procedures described, I agree to assume all expenses for moving and medically treating this student. I also hereby consent to any treatment, surgery, diagnostic procedures or the administration of anesthesia which may be carried out based on the medical judgment of the attending physician. By signing this form, I acknowledge understanding the purpose of the form and attest to the accuracy of the information.

Parent/Guardian Signature:_____Date_____

This information will be shared on a need to know basis with staff, administration and emergency medical staff in the case of an emergency unless you notify otherwise.

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING.
GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

☐	ADD/ADHD	☐	Allergies	☐	Asthma	☐	Autism
☐	Behavior	☐	Bleeding	☐	Body Piercing/Tattoo	☐	Bone/Spine
☐	Bowel/Bladder	☐	Chicken Pox	☐	Diabetes	☐	Emotional
☐	Hearing	☐	Heart	☐	Constipation/Diarrhea	☐	Kidney
☐	Physical Disability	☐	Seizures	☐	Frequent Cold/Sinus	☐	Surgery
☐	Vision	☐	OTHER_____				

If your child has an allergy requiring Benadryl_____and/or an Epi-Pen_____:

1) When was the child's last exposure? _____
2) How severe are the reactions? _____
3) Have they ever had to go to the Emergency Room because of the allergy? _____
4) Have they ever spent overnight in a Hospital because of the allergy? _____

Please be aware the permission forms for prescription and non-prescription medications are available on the website**. The medication must be in the original packaging or pharmacy labeled container (with child's name and prescribing Doctor on the label.** All medication must be within proper use dates (not expired).
Medication must be brought in by and sent home with a parent or guardian over 18 years of age (with the exception of self-carry asthma inhalers and Epi-pens where the parents and MD have signed a form and the form is on file with the Camp Advisor)

Parent/Guardian Signature:_____Date _____

*Please provide an updated Action Plan from the Medical Doctor your child sees to assist actions for your child with CHRONIC CONDITIONS: Please give any care plan, protocols, and/or emergency care plan. Childrenwith life-threatening conditions must have an emergency care plan in place. (Epi-pen users, Cardiac, Asthma, Diabetes, Seizures, etc.)

*Please be advised that there is **not** a school nurse on duty during summer camp. If your child has special needs that can only be addressed by a registered nurse, we do not have one on duty during our Summer Camp sessions.

Parent/Guardian Signature:_____Date _____

Parent/Guardian Signed Releases

Emergency Medical Care Consent: I hereby authorize emergency medical treatment for my child in the event I cannot be contacted to give permission to treat. I understand I will be financially responsible for the cost of such treatment.

☐ Yes ☐ No Initials_____

Transportation Consent: I hereby give my consent for my child to participate in any off-site activity during the summer camp program. Transportation to and from these activities will be provided via school bus which will be under the supervision of at least two (2) camp staff members.

☐ Yes ☐ No Initials_____

Media Consent: I hereby give permission for images of my child, captured during regular camp activities through video, photo and digital camera. Such images may be used solely for the purposes of ASPIRA Summer Camp and its partners in promotional material and publications, including the Las Américas ASPIRA Academy website and social media. I further agree to waive any rights of compensation or ownership thereto.
Note: Las Américas ASPIRA Academy has no authority to *disallow filming* of *schools from the street* or *sidewalk* off *property.*

☐ Yes ☐ No Initials_____

Sunscreen Release: I hereby give permission for ASPIRA Academy to apply spray sunscreen to my child.
I will supply spray sunscreen for my child, as well as apply to my child every morning.
ASPIRA Academy is not responsible for lost or stolen bottles of sunscreen, so please label your child's sunscreen. Counselors will not apply lotion to campers.

☐ Yes ☐ No Initials _____

Screen Time Release: I hereby give permission for my child to have appropriate screen time during Summer Camp.

☐ Yes ☐ No Initials_____

Discipline Policy

In order to provide a rewarding camp experience to everyone, it is important that your child behave appropriately. In the event that disciplinary action is warranted, the following steps will be taken:

1st Incident: To the best extent possible, the child will be removed from the other campers and provided with an explanation as to why their behavior was inappropriate. This will be a verbal warning.

2nd Incident: The camp staff will determine an appropriate consequence for the child's action. This may include restriction from further activity or quiet time away from other campers. The child's parent/guardian will be notified of the behavior problem.

3rd Incident: The parent/guardian will be notified and the child will be removed from camp.

For incidences involving serious misconduct (including but not limited to bullying, intimidation of fellow campers, fighting, etc.), the parent/guardian will be required to pick up the child. It is at the discretion of the Program Coordinator and Head of School for participants to be suspended or terminated from the program due to inappropriate behavior. **Any child removed from camp for misconduct will forfeit all registration and tuition fees. No refunds will be given.**

☐ Yes ☐ No Initials_____

I certify that my child is in good health and is amiable to normal discipline necessary for successful group experience. I understand that **I must submit a completed health appraisal before my child can participatein the summer program**. I also understand that the **deposits are non-refundable** and will hold my child's spot until the balance is due. Registration is not guaranteed until the balance is paid two weeks before the start of each session. **Failure to pay the balance by the due date could result in the cancellation of my registration. I understand that I will be responsible for the balance due should I not cancel at least two weeks in advance of the session. Money will not be refunded if/when a child is unable to attend the days paid in advance (due to sickness and/or other circumstances including suspension and/or expulsion) or for cancellations due to weather. The only reimbursements will be when care is cancelled by the school, or by the Summer Camp advisor.**

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Cancellation / Changes

Any cancellation or change must be submitted in writing two weeks prior to the change or cancellation date. All changes are subject to space availability and are not guaranteed. Refund must be requested in writing before April 30, 2025. All refunds will be subject to an $80 non-refundable fee. No refunds, or changes after May 1, 2025. **Money will not be refunded if/when a child is unable to attend the days paid in advance (due to sickness and/or other circumstances) or for cancellations due to weather. The only reimbursements will be when care is cancelled by the school, or by the Summer Camp advisor.**

Printed Name:_____Signature: _____
Child(ren):_____Date: _____

Late Pick-up Fee

I understand that there will be a late pick-up fee of $1.00 per minute from 5:30 until 5:40pm. After 5:40pm, $5.00 per minute will be charged. Late fee will be due at pick-up.

Printed Name:_____Signature: _____
Child(ren):_____Date: _____

Annual Parents Right to Know Notice Log-NCC

By signing this form, I am acknowledging I have received a copy of the Parents Right to Know Notice which states, "UNDER THE DELAWARE CODE, YOU ARE ENTITLED TO INSPECT THE ACTIVE RECORD AND COMPLAINT FILES OF ANY LICENSED CHILD CARE FACILITY." To review a child care facility's record, contact the administrative specialist, Office of Child Care Licensing, 3411 Silverside Road, The Concord | Hagley Building, Wilmington, Delaware 19810, phone (302) 892-5800.
You may also view substantiated complaints and compliance review histories by visiting the Office of Child Care Licensing's child care search at https://education.delaware.gov/families/occl/child_care_search/.

Parent/Guardian Name:_____Signature: _____
Child's Name:_____Date Received: _____

CHILD INFORMATION CARD
State of Delaware
Department of Education

Child's Information			
Child's name:	Date of birth:	Date of enrollment:	Date of discharge:
Child's address:		Hours and days child is scheduled to attend:	
Parent/Guardian Information (1) Emergency Contact/Authorized to Pick-up Child		**Parent/Guardian Information (2)** Emergency Contact/Authorized to Pick-up Child	
Name:		Name:	
Address, if different from child's:		Address, if different from child's:	
Home phone:	Cell phone:	Home phone:	Cell phone:
Work phone:	Hours of employment:	Work phone:	Hours of employment:
Employer name and address:		Employer name and address:	

Additional Emergency Contacts and People Authorized to Pick-up Child		
Name:	Address:	Phone:
Name:	Address:	Phone:
Name:	Address:	Phone:

☐ **Emergency Medical Care**

I,_____, the parent (or legal guardian) of_____, who is my minor child, hereby authorize emergency medical treatment for my child in the event I cannot be contacted to give permission to treat. I understand I will be financially responsible for the cost of such treatment.

☐ **Transportation**

I,_____, the parent (or legal guardian) of_____, who is my minor child, hereby give permission for my child to be transported by the licensee/staff/substitute.

_____ _____

Signature of parent/guardian Date

Medical Information	
Name of child's physician:	Office phone:
Special medical information, medications, allergies, diet:	Health insurance identification information:

The above information is necessary for your child's protection and this facility is required to have it. Keep this information current.

STATE OF DELAWARE
DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE LICENSING (OCCL)

Family Child Care Home
Large Family Child Care Home
Day Care Center
Youth Camp

NAME_____

BIRTHDATE_____

CHILD HEALTH APPRAISAL

SECTION A: TO BE COMPLETED BY PARENT BEFORE PHYSICAL EXAMINATION

CHECK IF CHILD HAS PROBLEMS WITH ANY OF THE FO LOWING: GIVE ADDITIONAL COMMENTS BELOW

❑ Allergies	❑ Frequent Colds	❑ Fainting	❑ Physical Handicap
(food, medicine, bee sting etc.)	❑ Hearing Difficulty	❑ Speech Difficulty	❑ Behavior Problem
❑ Constipation/Diarrhea	❑ Seizures	❑ Vision Difficulty	❑ Asthma

Other_____

Comments:_____

ADDITIONAL INFORMATION ABOUT YOUR CHILD (include serious illness, accidents, operations, medications, etc. with dates):_____

Parent/Guardian's Signature_____Date_____

SECTION B: TO BE COMPLETED BY EXAMINING PHYSICIAN/PEDIATRIC NURSE PRACTITIONER

CODE: X - Within Normal Limits O - See Remarks Below

_____ Scalp, Skin	_____Heart	_____Vision	_____Ear, Nose	_____Lungs
_____ Hearing	_____Throat	_____Abdomen	_____Blood Pressure	_____Eyes
_____ Genitalia	_____Teeth	_____Extremities	_____Neck, Glands	_____Nervous System
_____ Height	_____Weight			

REMARKS AND RECOMMENDATIONS: _____

IS CHILD PROGRESSING NORMALLY FOR AGE GROUP? _____

DTP/Hib 1 / /	DTP/Hib 2 / /	DTP/Hib 3 / /	DTP/ Hib 4 / /	DTaP/Hib 4 / /
DTP/DTaP 1 / DT / /	DTP/DTaP 2 / DT / /	DTP/DTaP 3 / DT / /	DTP/DTaP 4 / DT / /	DTP/DTaP 5 / DT / /
Td 1 / /	Td 2 / /	Td 3 / /	/ /	/ /
OPV/IPV 1 / /	OPV/IPV 2 / /	OPV/IPV 3 / /	OPV/IPV 4 / /	TB Screening 12 mo / /
MMR 1 / /	MMR 2 / /	HepB 1 / /	HepB 2 / /	HepB 3 / /
Hib 1 / /	Hib 2 / /	Hib 3 / /	Hib 4 / /	Hep B/Hib 1 / /
Hep B/Hib 2 / /	Hep B/Hib 3 / /	Varicella 1 / /	Varicella 2 / /	Influenza 1 / /
Influenza 2 / /	Pneumococcal Polysaccharide1 / /	Pneumococcal Polysaccharide 2 / /	Pneumococcal Conjugate 1 / /	Pneumococcal Conjugate 2 / /
Pneumococcal Conjugate 3 / /	Pneumococcal Conjugate 4 / /	Hep A 1 / /	Hep A 2 / /	Lyme Vax 1 / /
Lyme Vax 2 / /	Lyme Vax 3 / /	Other: / /	L[redacted]	Lead S creening 24 mo / /

Printed Name:_____Telephone:_____