



SHOREHAM-WADING RIVER CENTRAL SCHOOL DISTRICT
250B ROUTE 25A
SHOREHAM, NY 11786-2192

Phone: (631) 821-8116

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COMMUNITY PROGRAMS

Fax: (631) 821-0636

Website: swrschools.org

2025 "ROUND OUT" SUMMER DAY CAMP

JULY 7th thru AUGUST 8th

Monday to Friday ~ 9:00AM to 12PM

GRADES Kindergarten thru 5 (*entering Grade in Sept. 2025*)

We will not be accepting Pre-K

FEE: \$400.00 per child

Our ever popular "Round Out" summer fun camp will be back this summer. We will be holding Round Out at the **WADING RIVER SCHOOL** for the entire 5 weeks this year! Our program is staffed by qualified adult supervisors and our evaluated teens. The children will enjoy arts and crafts, recreational games and special activity theme days. Please register early! Any questions, please call the office at (631) 821-8116.

You may register by sending in a check (made out to SWR Community Programs) for this program and mail to the above address. Please include the medical history form and copy of your child's immunization record.

You can also pay ONLINE by going to the direct link swr.revtrak.net

If you register online, you must fill out and return the medical history form and copy of your child's immunization record to Shoreham-Wading River CSD, District Office, 250 B Route 25A, Shoreham, NY 11786.

PARENT / GUARDIAN MUST ESCORT AND PICK UP THEIR CHILD - ALL DAYS

Fee Schedule: \$400 for entire 5-week program
\$100 per week (in the same week)
\$ 25 per day

NO REGISTRATIONS AT CAMP. MUST COME TO DISTRICT OFFICE!

2025 ROUND OUT REGISTRATION & MEDICAL HISTORY PERMISSION FORM

Camper's Name _____ DOB _____ Grade in Sept 2025 _____

Mailing Address _____ Town _____ Zip _____

Home Phone # _____ Email Address: _____

Emergency Contact Person _____ Cell Number _____

☐ YES or ☐ NO to release photo on school web site

ATTACH COPY OF IMMUNIZATION INFORMATION or check yes below

☐ OKAY TO USE IMMUNIZATION RECORD IN INFINITE CAMPUS

HEALTH HISTORY (to be completed by parent/guardian)

Has your child ever had any of the following conditions? (please check Yes or No for each item)

| | YES | NO | | YES | NO |
|----------------------------|-------|-------|--------------------------------|-------|-------|
| Allergies/Hay Fever | _____ | _____ | Elevated Blood Pressure | _____ | _____ |
| Bee Sting Allergy | _____ | _____ | Headaches | _____ | _____ |
| Asthma | _____ | _____ | Head Injury/Concussion | _____ | _____ |
| Anemia | _____ | _____ | Heart Problem/Murmur | _____ | _____ |
| Arthritis | _____ | _____ | Frequent or Severe Nose Bleeds | _____ | _____ |
| Bladder/Kidney Problems | _____ | _____ | Ankle/Knee Pain/Injury | _____ | _____ |
| Convulsions/Seizures | _____ | _____ | Back Pain/Injury | _____ | _____ |
| Fainting Spells/Passed Out | _____ | _____ | Fractures/Dislocations | _____ | _____ |
| Diabetes | _____ | _____ | Spleen Injury | _____ | _____ |
| Eye/Sight Problems | _____ | _____ | Neck Pain/Injury | _____ | _____ |
| Ear/Hearing Problems | _____ | _____ | Nasal Problem/Fractures | _____ | _____ |
| Stomach Problems/Ulcer | _____ | _____ | Rheumatic Fever | _____ | _____ |

Does your child have special needs? _____
If so list what are they? _____

Does your child use an epi pen? _____

Is your child currently under medical care? _____

Has your child experienced chest pain/discomfort? _____

Has your child ever experienced shortness of breath/excessive fatigue w/exercise? _____

Does your child have uncorrectable loss of vision in one or both eyes? _____

Does your child currently have any orthodontic appliances? _____

Since your child's last medical visit, has there been a significant injury/illness? _____

Does your child have any Food Allergies? _____

If so list what are they? _____

Is your child currently taking prescription medications? _____

If so list the reason? _____

Note: This form must be completed, signed and returned to Community Programs office prior to first day of camp.

Parent/Guardian Signature _____ Date _____