Summer Camp
Application Checklist

Please be sure that all of the forms listed below are completed and that all fees are paid.

___ Application
___ Parental Agreement
___ Camper's Code of Conduct
___ Physical Examination Form
___ Allergy Form
___ Emergency Contact Form

To be completed with Director. Payment is determined by various factors.

___ Registration Payment
___ Payment agreement form

SUMMER CAMP

-A program of The Center for Life and Faith-

APPLICANT AND FAMILY INFORMATION

CAMPER'S NAME:

DOB: ___/___/_____ **AGE:** _____	**T-Shirt Size:** ___Sm. ___Med. __Lrg. ___Adult Sm. ___Adult Med. ___Adult Lrg.	**Male or Female** **(Circle One)**
Address:	**City, State:**	**ZIP Code:**
School:	**Grade Entering in September:**	**Teacher:**
IEP: Yes No (circle one)	**If yes, list the special needs diagnosis:**	**Medication: Yes or No**
Guardian # 1 Name:	**Primary number:** **Secondary number:**	**Relationship:**
Guardian #2 Name:	**Primary number:** **Secondary number:**	**Relationship:**

EMPLOYMENT INFORMATION

Parent/ Guardian Name 1:	**Current employer:**	
Employer address:		**How long?**
City:	**State:**	**Zip:**
Phone:	**Email:**	**Fax #:**
Position:	**Hourly or Salary $**	**Weekly income:** **Annual income:**

Parent / Guardian Name 2:	**Current employer:**
Employer address:	**How long?**

City:	State:	Zip:
Phone:	Email:	Fax #:
Position:	Hourly or Salary *$*	Weekly income: Annual income:

PICK UP LIST

Name:	Address:	Phone:
1.		
2.		
3.		
4.		

_______ I understand that my child will not be released to any person not authorized on this form.
_______ I am the only one who is able to pick up my child.
_______ My child has permission to leave without an escort each day at 5:00 pm.

Parental Agreement

Registration: I understand there is a non-refundable **$50.00** registration fee for a single child and a **$75.00** for those families who have more than one child. This fee secures your child's space for afterschool.

Payment: I understand all fees must be paid on time according to the payment arrangement I have entered into with the Summer Camp. If I have agreed that a 3rd party will pay the camp fees and they do not, I am responsible for those fees before the close of Summer Camp.

I understand that summer camp fees must be paid on time or I risk having my child suspended from summer camp or not able to return until my financial obligations are met.

Conduct: I understand that my child must comply with the rules and standards of conduct and that the organization may terminate my child's participation in the camp if he/ she does not maintain these standards.

Lost or stolen. The Church of the Resurrection and The Booker T. Washington summer camp are not responsible for lost, stolen or damaged personal articles. Camp is a busy place with lots of children moving about, please label all items to help your child keep track of his/her items. Do not send extra toys, games or personal items that may be misplaced.

Trips: I permit my child to attend full day, half day and local neighborhood trips. This is a general consent form. I will also sign a TRIP ITINERARY FORM,

Pick up and Drop Off: Your child must be picked up from camp on time by the designated person/people on their pick-up list. BTWSC does not assume the risk for any child that travels to or from the church without supervision or authorization. The BTWSC assumes no responsibility for children once they leave the premises.

Injury: I understand and acknowledge that participation in camp activities may involve inherent risks of injury, including risks associated with transportation by walking and taking public transportation, as well as regular use of playgrounds, amusement park rides, toys and water rides.

Photo Release: I give permission for my child's photo, image or likeness to be reproduced for the purpose of marketing and communicating on various platforms including marketing materials, website and social media sites that are used solely for promoting the work of BTWLC. My child's name will not be used with their photo to identify them individually.

I hereby grant COR and BTWSC and its agents full authority to take whatever actions they deem necessary regarding my child's health and safety, and I fully release them from any liability. I understand that prudent attempts will be made to contact the undersigned immediately, in the event of an emergency. I understand that I will be responsible for payment of all medical and medication bills.

Parent Name: ____________________ **Parent Signature:** ____________________ **Date:** / /

Camper's Code of Conduct

- Campers must be escorted to camp on time each morning. Camp begins at 8:00am and ends at 5:00pm. If you come after 8:30, breakfast will be over. Pickup is between 5:00 pm and 5:30 pm
- Only an authorized person on the pick-up list can pick-up a camper and they must be on time.
- No child will be accepted into camp after 9:00 am **without a valid excuse or emergency**, and parents / guardians must call if they expect their child to be late or absent.
- Children are not to curse and / or use profanity, fight, speak disrespectfully to staff, adults, other campers, and / or volunteers or vandalize any property. **Violation of these rules can lead to suspension or dismissal.**
- Camp T-shirts must be worn on all trips so that Booker T. campers can be easily identified.
- Campers should wear appropriate clothing. No obscene or revealing clothing on any campers will be permitted.
- All campers must participate fully in every aspect of the academic and enrichment program.
- Campers must **bring lunch on full day trips**. Please refer to your camp calendar.
- **Every Friday,** campers must bring swimsuits and towels on appropriate playground sprinkler days. Also, no flip flops are permitted anytimes!
- Campers are encouraged to eat nutritious snacks and should not bring junk food to camp.
- The Booker T. Washington Learning Center is a smoke-free and drug-free environment. This applies to campers and caregivers.

I reviewed these rules with my child and we agree to abide by them. I understand these rules are to foster a fun, safe and productive environment where all children can thrive.

Parent/Guardian's Name: ________________ Child's Name: ____________________

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS ☐☐☐☐☐☐☐☐☐

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* __ / __ / ____

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

City/Borough | State | Zip Code | School/Center/Camp Name | District Number __ __ | **Phone Numbers** Home ____ Cell ____ Work ____

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** ☐ **Foster Parent** Last Name | First Name

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*
☐ Uncomplicated ☐ Premature: ______ weeks gestation
☐ Complicated by ______

Allergies ☐ None ☐ Epi pen prescribed
☐ Drugs *(list)* ______
☐ Foods *(list)* ______
☐ Other *(list)* ______

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
If persistent, check all current medication(s): ☐ Inhaled corticosteroid ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* ______

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)* ☐ None ☐ Yes *(list below)*

Dietary Restrictions ☐ None ☐ Yes *(list below)*

PHYSICAL EXAMINATION

Height ______ cm (____ %ile)
Weight ______ kg (____ %ile)
BMI ______ kg/m^2 (____ %ile)
Head Circumference *(age ≤2 yrs)* ______ cm (____ %ile)
Blood Pressure *(age ≥3 yrs)* ____ / ____

General Appearance:

Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	Abnl	
☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development
☐	☐	Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language
☐	☐	Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	Behavioral

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below
☐ Cognitive *(e.g., play skills)* ______
☐ Communication/Language ______
☐ Social/Emotional ______
☐ Adaptive/Self-Help ______
☐ Motor ______

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__/__/__ __/__/__	____ µg/dL ____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__/__/__	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
— Head Start Only —		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	____ g/dL ____ %

	Date Done	Results
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration ____mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ Nl ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* __ / __ *Left* __ / __ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child ☐☐☐☐☐☐☐☐☐

Hep B	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus		__/__/__	__/__/__	__/__/__
DTP/DTaP/DT		__/__/__	__/__/__	__/__/__
		__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__	__/__/__

Influenza	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__	
Td	__/__/__	__/__/__	__/__/__
Tdap __/__/__ Hep A		__/__/__	__/__/__
Meningococcal	__/__/__	__/__/__	
HPV	__/__/__	__/__/__	__/__/__
Other, *Specify:* ______	__/__/__;	______	__/__/__

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet
☐ Restrictions *(specify)* ______
Follow-up Needed ☐ No ☐ Yes, for ______ Appt. date: __/__/__
Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision
☐ Other

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

Health Care Provider Signature | Date __/__/__ | **DOHMH ONLY** **PROVIDER I.D.** ☐☐☐☐☐☐

Health Care Provider Name and Degree *(print)* | Provider License No. and State | **TYPE OF EXAM:** ☐ NAE Current ☐ NAE Prior Year(s)

Facility Name | National Provider Identifier (NPI) | *Comments*

Address | City | State | Zip | Date Reviewed: __/__/__ | I.D. NUMBER ☐☐☐☐☐☐

Telephone ( ) ___ – ____ | Fax ( ) ___ – ____ | REVIEWER:

Copies: **White** School/Child Care/Early Intervention/Camp **Canary** Health Care Provider **Pink** Parent/Guardian

Allergy / Food Preference Form

Child's Name:______________________________ D.O.B.___________________

1. Does your child have any allergies? (please circle)

YES NO

Please list the allergy:____

If you answered YES, please obtain an Allergy Action Plan from administration, and have the form completed by your child's doctor.

2. Are there any foods that you do not wish for your child to eat / drink while in school? If so, please list them below;

Food Preferences (Food preferences differ from food allergies, in that they are excluded from the child's diet by choice.)

____

____

____

____

(Please keep in mind that we do not serve pork, and we are a nut-free school)

325 East 101st St. New York, NY 10029
Office; 551-246-1260
btwpreschool@gmail.com

EMERGENCY CONTACT
Summer Camp 2024

Student: Last Name____________________ First ______________________ MI________ DOB_________ Sex ______

Parent / Guardian (Student resides with): ______________________ Relationship ____________________
Parent's Preferred Language of Communication: Written______________________ Oral ______________
Home Telephone_______________ Work Telephone ___________________________
Cell No. __________________ E-mail____________________________
Address __________________________ Apt._______ Borough _______________ Zip ______________

OtherParent / Guardian: _______________________________ Relationship_________________
Other Parent's Preferred Language of Communication: Written______________________ Oral ______________
Home Telephone_______________ Work Telephone ___________________________
Cell No. __________________ E-mail____________________________
Address __________________________ Apt._______ Borough _______________ Zip ______________

List below names of three (3) persons who may be called in case of emergency or if a child gets sick in camp. CHILD WILL BE RELEASED ONLY TO PERSONS NAMES ON THIS CARD.

Name_________________________ telephone_____________________ Relationship____________________
Name_________________________ telephone_____________________ Relationship____________________
Name_________________________ telephone_____________________ Relationship____________________
Name_________________________ telephone_____________________ Relationship____________________

If there is a person who may NOT HAVE ACCESS to child, please indicate:
Name_________________________ Relationship_____________________ Order of Protection Exists? Yes__ No___

Director will be notified in writing if any changes to information on this card

Parent Signature ____________________ Date ____________________