Contact Information

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2022 SUMMER CAMP REGISTRATION PACKAGE

CAMP DATES: Tuesday, July 5 - Friday, August 12, 2022

Please select one:
Camper will receive 3 shirts to be worn Monday-Friday

Camp shirt size: _____
Each additional shirt $10:_____

___**Regular Day Hours: 8:00am- 4:00 pm.** ($1000 per camper, $800 sibling discount)
Horario normal: 8:00am - 4:00pm

___ **$75 Round trip transportation weekly**

___ **$50 One way transportation weekly**

(Please print clearly**/Imprima por favor claramente**)
CHILD INFORMATION/ *INFORMACIÓN DEl NIÑO/NIÑA*

Last Name: _____ First: _____ Middle: _____
Apellido *Primer Nombre* *Segundo Nombre*

Age: _____ Date of Birth: _____ Male or Female (circle one)
Edad *Fecha de Nacimiento* *Niño o Niña (Circúle uno)*

Street Address: _____ Apt #: _____
Dirección *Apartamento*

City: _____ State: _____ Zip: _____
Ciudad *Estado* *Código postal*

Home Telephone #: (_____)_____
Número de teléfono de casa

PARENT/GUARDIAN INFORMATION/*INFORMACIÓN DE PARIENTES/GUARDIAN*

First Name: _____Last Name:_____ Relationship: _____
Apellido *Primer Nombre* *Relación*

Daytime phone #: _____ Evening #: _____ Cell #: _____
Número de teléfono de día *Número de teléfono de noche* *Número de celular*

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EMERGENCY CONTACTS/*CONTACTOS DE EMERGENCIA*

1. Name/*Nombre*:_____ Relationship/*Relación*: _____
   Day Phone Number/ *Número de teléfono de día*: _____
   Evening Phone Number/ *Número de teléfono por la noche*: _____

2. Name/*Nombre*:_____ Relationship/*Relación*: _____
   Day Phone Number/ *Número de teléfono de día*: _____
   Evening Phone Number/ *Número de teléfono por la noche noche*: _____

3. Name/*Nombre*:_____ Relationship/*Relación*: _____
   Day Phone Number/ *Número de teléfono de día*: _____
   Evening Phone Number/ *Número de teléfono por la noche*: _____

ESCORT PICK-UP LIST/*AUTORIZADOS PARA RECOGER*

My child (is / not) allowed to go home alone at dismissal. (Please circle one)
*Mi hijo/hija **(tiene / no tiene)** el permiso para regresar a la casa solo/sola al despido. (Por favor circúle uno)*

Note: This option is only available for children over the age of 10 years.
Favor de notar: Esta opción es solamente para niños/niñas sobre la edad de 10.

If no, I understand that my child will not be permitted to leave SayChēeeze Day Camp with anyone who is not indicated on this list without proper notification in advance*. I wish for my child to be picked up at the Recreation Center by one of the following authorized persons:

Si no, comprendo que mi hijo/hija no sera permitido dejar el centro de recreo con nadien que no es indicado en este formulario sin notificación apropiada en el avance. Yo deseo que mi hijo/hija sea recogido por una de la siguiente personas authorizadas:*

1. Name/*Nombre*:_____Relationship/*Relación*: _____

2. Name/*Nombre*:_____ Relationship/*Relación*: _____

3. Name/*Nombre*:_____ Relationship/*Relación*: _____

***** I agree to notify the Camp Director – in person or by letter -- of any changes to the escort pick-up list. I understand that I must inform anyone other than myself to show proper photo identification.

******Concuerdo en notificar el Director de Campamento – en persona o por carta – de cualquier cambio en authorizados para recoger a mi hijo/hija. Cuando individuales aparte que yo, recogen a mi hijo/hija,yo comprendo que yo les debo para informar para que demuestren identificación.*

MEDICAL/*HISTORIA MÉDICA*

Does your child have health insurance? YES__ NO__ Health Insurance Provider: _____
Tiene su hijo/hija seguro medico? Sí No Providor de Seguro Medico

Does your child have any of the following? If so please list them below:
Tiene su hijo/hija cualquiera de los siguientes? Si eso es el caso, por favor liste abajo:

Allergies:_____ Medications: _____
Alergias Medicinas

Asthma? YES__ NO__
Asma Si No

If yes, will your child ever use an inhaler during summer camp? YES__ NO__
Si eso, es el caso, alguna vez utilzará su hijo/hija un inhalante durante campamento de verano? Si No

Physical/Medical Problems: _____
Problemas fiscio o medico

PARENT /CHILD CODE OF CONDUCT

I request that the Summer Day Camp Program provide a safe and friendly environment for my child/ren where they can be enriched in a variety of activities that are important for well rounded education and recreation. Therefore, I agree to the following terms and conditions:

Discipline Policy: I understand that my child must display appropriate behavior at all times. This includes following directions, respecting others and using appropriate language. I understand that I will be notified in person and/or in writing if my child exhibits inappropriate behavior (such as bullying, hitting, cursing, fighting and touching another person or their belongings.) I agree that if my child displays any of the inappropriate behaviors, they will be given one or more of the following: a verbal warning, a Final verbal warning, Director/Parent conference or dismissal from the program. I agree if my child is a danger to themselves or others that my child will be removed from the program immediately. I understand that all suspensions and dismissals are at the discretion of the Camp Director.

Note: There are no refunds for days missed due to suspensions/dismissal.

X_____ X_____
Parent Signature Camper Signature

Health Records: I agree to provide the Camp with a current Department of Health medical form for my child before admission to the program and I agree to update the form yearly. The completed health record must be submitted by Monday, June 27, 2022.

Medical Records: I authorize the Saycheeeze Summer Camp to obtain necessary and immediate medical treatment for my child with the understanding that I or a family member will be notified as soon as possible.

Picture Release: I hereby give my permission for the Saycheeeze Summer Camp use my child's photograph or image for display or publicity.

Swimming Release: I hearby authorize Saycheeze summer camp to take my child to pools and field trips.

Trip Consent: I hereby give consent for my child to participate in any off-site field trips, which may be part of the Summer Day Camp Program.

Pick Up/ Late Pick Up: I understand that Summer Day Camp regular day program hours are 8:00 a.m. – 4:00 p.m. and students must be picked up by then. Parents are expected to pick up their child promptly at the close of the program. I understand that if I am late picking up my child more than 3 times, I am required to attend a parent conference and will receive a warning. If I am late picking up my child more than 5 times, my child will be terminated from the program. I agree that if I or anyone listed on the escort list are continuously late picking up my child and/or all attempts to contact me and the emergency contacts have been exhausted, termination from the program is a possibility. I understand that if my child is not picked up by 6:00p.m., that staff members have been advised to escort my child to the nearest precinct.

X_____
Parent Signature

Safety: The Camp reserves the right to dismiss from the camp any child that does not adhere to the Summer Day Camp's safety regulations.

Fees: **Full payment of $1000 is encouraged upon registration.**
However, a payment plan is available if necessary. An initial deposit of $250 is due ASAP with the signed application package for regular day. Payment is:

Accepted via cash or money order made out to Saycheeeze

Please note we do not offer refunds. Balance is due June 27, 2022.

____I take full responsibility that all the information in this Summer Day Camp Application is correct to the best of my knowledge (I agree to inform the Camp Director of all changes in address, home, work and emergency telephone number immediately after these changes occur).

____I understand that there are no refunds

FOR OFFICIAL USE ONLY

Birth certificate (due upon registration) **Date submitted: _____** **Entered by (name of staff): _____**

Child Health Record

Date submitted: _____

Date CHR expires: _____

Reviewed by (name of staff): _____

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 corticosteriod ☐ 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/m²** (__ __ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (__ __ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

NI Abnl		*NI Abnl*		*NI Abnl*		*NI Abnl*		*NI 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)*	__/__/__	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 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 __/__/__

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

DOHMH ONLY **PROVIDER I.D.**

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: __/__/__ **I.D. NUMBER**

REVIEWER:

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