York College
SUMMER CAMP 2017

GENERAL INFORMATION /EMERGENCY CONTACT

On behalf of the Continuing and Professional Education Department, Welcome to the Summer Camp Program. Providing a smooth and successful program for your child is our goal. Please assist us by paying close attention to the information provided below:

1. Medical Clearance forms must be completed by your physician and returned by Thursday, June 22nd.
2. Program start date: Monday, July 3, 2017 at 8:00am
   Program end date: Friday, August 4, 2017
3. Program meet Monday through Friday (8:00 to 5:00pm)
4. All children enrolled in the program may be dropped off at 7:15 am. Those enrolled in the full day program must be picked up by 6:00pm. It is imperative that your child is picked up on or BEFORE 6pm as this is the time that the staff ends their day. After 15 minutes, you will get a warning one-two times, after that, you risk having your child discharged from the program. Children should be dropped off at the Classroom Building, located at 94-43 160th Street and pick-up _____at the Health and Physical Education Building, located at 160-02 Liberty Avenue.

Additionally, you are required to provide the information requested below:

1. Parent/ Guardian Name: _____

   Contact Number: _____

   Parent/ Guardian Name: _____

   Contact Number: _____
2. Emergency Contact Name: _____

   Contact Number: _____
3. What steps would you like us to take in the event of an emergency, if contact cannot be made with either the parent/guardian or another designated adult?

   _____

   _____
4. What size T-Shirt does your child wear? (Circle one Size)

   Children: S (6-8) M (10-12) L (14-16) XL (18-20)

   Adult: S M L XL 2XL

   1st Tee-shirt Free – additional tee-shirts are $10.00 each.

   Please sign and return this acknowledgement on or before orientation.
   Thank You for choosing York College's Summer Camp Program
5. Print Camper Name, age & grade (entering for the fall): _____

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Parent/Guardian Signature: _____ Date: _____

CODE OF CONDUCT

A safe environment is critical if quality teaching and learning are to take place in our Summer Camp Program. A key element in producing such an environment is to ensure that parents understand the rights and responsibilities of their children while attending Camp. Students must know what conduct is expected of them and what the consequences are for unacceptable behavior.

Unacceptable behavior is defined as verbal or physical activity which may involve, but is not limited to:

- Behavior that requires constant attention from the staff
- Inflicts physical or emotional harm on other children
- Abuses the staff and/or ignores or disobeys the rules that guide behavior during program hours

Please review the rules stated below and discuss the implications with your child.

All Campers must:

- Show respect for fellow campers, and camp staff;
- Speak for himself, not for anyone else;
- Play safely and fairly;
- Follow all facility rules;
- Respect the campus and keep the facilities clean

Failure to comply with this code of conduct will be addressed in the following way:

1st Action: Verbal Warning – The student will be given a verbal warning by one of the camp staff. The Camp Manager will speak to the parent regarding the child's infraction.

2nd Action: (Parent Warning) - The Camp Manager will speak to the parent – If the behavior continues.

3rd Action: Dismissal from the program – Continued bad behavior indicates an unwillingness to comply with the Camp's code of conduct and will result in removal from the program. Tuition will be forfeited.

If a child can not adjust to the camp setting and behavior is inappropriate, the child may be discharged. Know that reasonable efforts will be made to help children adjust to the camp setting.

Camper Name, age & Grade (entering for the fall): _____

Parent/Guardian Signature: _____ Date: _____

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PICK-UP PROCEDURE

After completion of the final daily activity, my child/children listed below:

Name	Grade (entering in the fall)
Name	Grade (entering in the fall)
Name	Grade (entering in the fall)
Name	Grade (entering in the fall)

Will (Circle one or both)

a. Be picked-up by

Name	Phone Number
Name	Phone Number
Name	Phone Number
Name	Phone Number

b. Leave independently.

If you pick your child up after 6:00pm, you will:

- 1st Action: Get a verbal warning
- 2nd Action: Get a written warning
- 3rd Action: Risk discharge from Camp – Tuition will be forfeited.

If a change should occur, I will provide advance notice to the Continuing Education Center at (718) 262-2790.

Parent/Guardian Name (Print): _____

Parent/Guardian Name (Signature): _____ Date: _____

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MEDIA RELEASE FORM

York College, the City University of New York
94-20 Guy R. Brewer Blvd.
Jamaica NY 11451

Permission to use photograph(s) taken in Summer Camp

I grant York College, its representatives and employees, the right to take photographs of me and my child/Children in connection with the above-identified program. I authorize York College, its assigns and transferees to copyright and publish the same in print and/or electronically.

I agree that York College may use such photographs of me for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and web content.

I have read and understand the above:

Student Name: _____Age:_____

Parent/Guardian Name (Print): _____

Parent/Guardian (Signature): _____

I prefer that my child _____ not be photographed.

Parent/Guardian (Signature): _____

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REQUEST FOR BREAKFAST, LUNCH AND SNACKS

Children are free to bring their own breakfast, lunch and snacks. However, free breakfast and a bag lunch (from the Department of Education's Food Service Program) will be provided to your child daily if you request it at the start of the program. The camp will also supply a healthy snack, water and/or 100% juice each afternoon around 3 or 4 pm at no cost to the campers or parents. The meal schedule and food selections will be distributed to the parents during the parent orientation scheduled on Thursday, June 22nd.

If you want your child to receive free meals, please indicate your preference below & sign.

Breakfast:

Cereal_____ bagel/roll_____ fruit _____ Juice_____

Lunch:

Meat sandwich _____ Peanut butter and jelly sandwich _____

Snack:

Energy bar: _____ Juice_____ Water_____

All children are encouraged to bring two (2) healthy snacks for break times, and a bottle of frozen water.

Thank you for your cooperation.

Child's Name: _____ Age: _____

Parent/Guardian Signature: _____ Date: _____

SUPPLEMENTAL INFORMATION

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All parents and or legal guardians registering their child for summer camp, academic preparation or other youth programming must complete the following information:

1. Child's First Name_____ Last Name_____

2. Child's Address and Phone (if different than yours)
   _____
   _____

3. Are you the parent or guardian and primary contact during the course in which the child is being enrolled? _____Y _____ N

   (If no, primary applicant information must be that of parent / guardian)

4. You are required to comply with NYC DOE parameters on matters related to your child's health. Please have your child's primary care physician complete the medial form attached to this application due to Continuing Education Office on or before June 23rd.
5. Does your child possess an IEP or 504 accommodations?

   _____Y _____N

   If yes, the CPEC reserves may not be able to provide adequate services to meet your child's needs. Please see terms and conditions.

6. What is your child's most recent report card grade in

   ELA _____

   Math_____

7. What was your child's most recent state test or Regents test score in:

   ELA _____

   Math_____

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TRIP ITINERARY AND PARENTAL CONSENT FORM

Camp Name: York College Summer Getaway **CAMIS/RECORD ID# 41585402**

Camp Address: 94-20 Guy R. Brewer Blvd., Jamaica, NY 11451

Date	Destination & Address	Mode of Transportation	Activates	Consent
July 7th	**Queens Zoo** 53-51 111 St. Corona, NY 11368	**Bus**	**Tour**	**Yes ( ) No ( )**
July 14th	**Hall of Science** 47-01 111 St. Corona, NY 11368	**Bus**	**Tour**	**Yes ( ) No ( )**
July 21st	**Ripley's Believe It or Not** 234 W. 42nd St. NYC	**Bus**	**Tour**	**Yes ( ) No ( )**
July 28th	**Queens Museum** NYC Building Corona, NY 11368	**Bus**	**Guided Tour**	**Yes ( ) No ( )**
August 4th	**Queens Botanical Gardens** 43-50 Main St. Flushing	**Bus**	**Tour & Planting**	**Yes ( ) No ( )**

Parental Consent:

I, _____, the parent/legal guardian of _____, age: ___ hereby give permission for him/her to participant in the trips and activities as indicated on the above itinerary. Signature: _____ Date: _____

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** Last Name First Name ☐ **Foster Parent**

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

DOHMH ONLY PROVIDER I.D.

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

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (___ ___) ___ ___ ___ – ___ ___ ___ ___ | Fax (___ ___) ___ ___ ___ – ___ ___ ___ ___

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