@CampHenry301

HENRY STREET SETTLEMENT

CAMP HENRY

FOR OFFICE USE ONLY
Date Received: _____
Received By: _____

CAMP HENRY APPLICATION

Contact Info: Jon Pena | 646.887.5232 | jpena1@henrystreet.org

CAMPER INFORMATION

☐ Returning Camper ☐ New Camper

Name: _____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Camper Cell Phone: _____ Ethnicity: _____

Sibling attending camp: _____ Current School: _____

Grade as of September 2019: _____ OSIS #: _____

What languages are spoken in the camper's home? _____

PARENT/GUARDIAN INFORMATION

Primary Guardian Please note that the person filling out this registration form is considered the Primary Guardian and is the only one authorized to make changes to the application. Should such changes be necessary, they are to be done in writing only by the Primary Guardian.

Name: _____ Relationship to Camper: _____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Primary Language Spoken: _____

Employer (if unemployed, write "None"): _____

Job/Position: _____ Work Phone: _____

Secondary Guardian

Name: _____ Relationship to Camper: _____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Primary Language Spoken: _____

Employer (if unemployed, write "None"): _____

Job/Position: _____ Work Phone: _____

Is the above person authorized to pick up my child at the end of each day or in the event of an emergency?

☐ Yes ☐ No

Camper Name: _____

EMERGENCY CONTACT INFORMATION

The first attempt will be made to contact the camper's parents/guardians. Emergency Contacts listed below must be a maximum of 20 minutes away from Henry Street Settlement and be able to pick your child up in the event of an emergency. Please notify us immediately through writing if this information changes over the course of the summer.

Emergency Contact 1

Name: _____ Relationship to Camper: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Primary Language Spoken: _____

Is the above person authorized to pick up my child at the end of each day or in the event of an emergency?

☐ Yes ☐ No

Emergency Contact 2

Name: _____ Relationship to Camper: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Primary Language Spoken: _____

Is the above person authorized to pick up my child at the end of each day or in the event of an emergency?

☐ Yes ☐ No

Emergency Contact 3

Name: _____ Relationship to Camper: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Primary Language Spoken: _____

Is the above person authorized to pick up my child at the end of each day or in the event of an emergency?

☐ Yes ☐ No

GENERAL INFORMATION

How did you find out about Camp Henry? ☐ Facebook ☐ Twitter ☐ Instagram

☐ Other (Please specify): _____

Has the camper previously participated in a Henry Street Settlement Program? ☐ Yes ☐ No

If yes, what program(s)? _____

CAMP HENRY RULES ON DROP OFF & PICK UP

A camper 12 years of age and older will be able to be dismissed from Camp Henry on their own and escort any younger siblings home **ONLY** if Camp Henry is given written permission from the primary/custodial guardian. Campers 12 years and older will not be allowed to escort non family members home, nor will they be able to leave camp until the general camp dismissal time.

For all other children, only a parent or guardian or sibling that is **18 years of age or over** may pick them up and escort them home.

If your child is under 12 years of age, they cannot be dropped off and expected to sign themselves in. The sign-in sheet is not allowed to be brought out to you. All campers must be signed in by a parent, guardian, or sibling that is listed on registration. You may add names, but only in writing via a camp director or camp registrar.

Please be advised that you will not be able to drop off your child after the designated check in time. The participants move throughout the neighborhood and the boroughs and we will be unable to accommodate those who arrive late because students will already be fully engaged in activities or travel.

Participants are not allowed to be picked up early except in the instances of emergencies. Even then, your child might not be in the 301 building or they may be involved in an activity that cannot be interrupted. Please be patient while we accommodate you.

Please Check One:

☐ I hereby give my child, who is at least 12 years old, permission to go home unescorted.

☐ I do not give my child, who is at least 12 years old, permission to go home unescorted.

☐ I hereby give my child, who is at least 12 years old and is a camper at Camp Henry, permission to escort his/her younger sibling(s) home.

Camper Name: _____

IMPORTANT CHECK-OFF ITEMS

Please list ALL allergies your child may have, no matter how mild:

_____

_____

_____

Please list any food restrictions your child may have for cultural, religious or medical reasons:

_____

_____

_____

Check off your child's aquatic skill level (all that apply):

☐ Doesn't know how to swim ☐ Doggy Paddle ☐ Float ☐ Swim

Check off your child's t-shirt size:

Child: ☐ S ☐ M ☐ L ☐ XL Adult: ☐ S ☐ M ☐ L ☐ XL ☐ XXL

PLEASE INITIAL EACH STATEMENT

_____ A deposit of $100 must accompany this application. The deposit is for registration and is **NON REFUNDABLE**. **The tuition payment is due in full no later than June 21.** After June 21. only 50% of paid tuition is refundable if you withdraw by the mentioned date. No child will be permitted to attend camp without payment in full by the above-mentioned date. Money orders should be made out to Henry Street Settlement or we accept Visa, MasterCard, or Discover credit cards.

_____ No child will be properly enrolled in Camp Henry for the 2019 summer without the following paperwork **FULLY** completed by **JUNE 21, 2019: I understand that my child(ren) will not be able to attend camp unless the following items are on file:**

- **Fully completed camp application**
- **Accurate and up to date medical form**
- **Copies of their signed immunization record**
- **Current insurance card**

_____ If child does not attend camp, the entire fee paid to date of this notice will be forfeited. **No refund** will be granted if the camper leaves on his/her own account or is removed from camp due to an inability to adjust or to comply with the camp rules or is unable to function adequately. **There is no reduction/ refund based on missed days due to absence, illness or to early withdrawal.**

_____ I am aware that my child must follow the rules and regulations of the summer camp program and may be terminated from Camp Henry if he or she does not comply.

_____ I hereby consent to the taking of photographs, movies, internet use, and videotapes, of my child by Henry Street Settlement or its designated representatives. I also grant the right to edit, use, and re-use said products for any and all educational, public service, or not for profit purposes selected by Henry Street Settlement and release any and all rights, title, and interest we or the child may have in said products. Photocopies and facsimiles of this release and consent shall have the same legal effect as the original.

_____ I understand that I, or a designated family member, must attend a camp orientation in order to complete my registration process.

_____ Camp Henry is not responsible for any personal items (cell phones, hand-held devices, toys) that are lost, stolen and/or damaged while attending camp.

_____ If there is an emergency that requires me to pick my child up early from camp, I understand that I am expected to contact the camp office immediately to give them as much time as possible to accommodate us.

_____ If your child has a cell phone on them, it will not be activated during camp hours.

_____ I consent that in an emergency Henry Street Settlement may act in loco parentis and obtain medical treatment if necessary. I understand that if medical treatment is deemed necessary I will be informed as soon as possible.

_____ I give my permission for Henry Street Settlement staff to take my child on walking field trips as a part of their summer day camp activities. This includes, but is not limited to, neighborhood parks, Abrons Arts Center, events at other public spaces, camp programs at 301 Henry Street, Boys & Girls Republic, P.S. 20, etc. I understand that for any field trip involving transportation, I will receive a permission slip specific to that particular trip.

Camper Name: _____

I reviewed the application and all the information provided is accurate and true. I agree to all the terms and conditions.

Parent/Guardian Signature: _____ **Date:** _____

How did you hear about Camp Henry?

- ☐ **Returning campter**
- ☐ **Henry Street Settlement**
- ☐ **In the community**
- ☐ **Red Tricycle**
- ☐ **Big Apple Parent**
- ☐ **The LoDown**
- ☐ **Other:** _____

Please return completed application, medical form, and CACFP Form (found on the next 3 pages) to:

Attn: Camp Services
Henry Street Settlement
301 Henry Street, 3rd Floor
New York, NY 10002

NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

Income Eligibility Form
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME _____

Print the name of the child(ren) enrolled in this child care center

1. _____ 2. _____ 3. _____

DIRECTIONS

Complete SECTION A if anyone in your household
1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case # _____

TANF # _____

FDPIR # _____

Names of Foster Children _____

_____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature _____

Date _____

FOR SPONSOR USE ONLY

CACFP Agreement # _____

Total Number of Household Members _____
(INCLUDING FOSTER CHILDREN, IF APPLICABLE)

Total Household Income $ _____

Free _____ Reduced _____ Paid _____

Date of Determination _____

Signature of Center Staff _____

Complete SECTION B if no one in your household participates in SNAP, receives TANF, participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____
7. _____	$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature _____

Print Name _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER ☐☐☐☐ DATE _____

USDA is an equal opportunity provider and employer.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the form. The Social Security Number is not required when you: apply on behalf of a foster child; provide a SNAP, TANF or FDPIR number; or when you indicate that the adult household member signing the form does not have a Social Security Number. We will use your information to determine if the center is eligible for free or reduced-price meal reimbursement and for administration and enforcement of the Program.

INSTRUCTIONS FOR COMPLETING DOH-3688

Definition of Income

Income means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) Social Security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) unemployment compensation; (7) government civilian employee or military retirement, or pensions or veteran's payments; (8) private pensions or annuities; (9) alimony or child support payments; (10) regular contributions from persons not living in the household; (11) net royalties; (12) military benefits received in cash, such as housing allowance except if you are in the Military Housing Privatization Initiative; and (13) any other cash income.

Definition of Household

Household means *family* as defined in Section 226.2. *Family* means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

INSTRUCTIONS FOR PARENTS OR GUARDIANS

Write in the name of the child care center in the space provided.

Print the name of each child in your household who attends this child care center.

Section A: If anyone in your household participates in the Supplemental Nutrition Assistance Program (SNAP), receives Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the SNAP, TANF or FDPIR number (do not use your ACS or DSS child care subsidy number). Then sign and date the form and return it to the day care center.

Foster children: If your household includes a foster child who is in child care, write in the names of the foster children.

Section B: Complete this section if you did not complete Section A. Write in your name and the names of all other adults and children living in the household, including unrelated people, even if they do not have any income. Do not include the children in child care who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household, above. If any amount last month was more or less than the usual, write in that person's usual income.

The last four digits of the Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*. The form must be signed by an adult member of the household.

INSTRUCTIONS FOR CENTERS AND SPONSORS

The *For Sponsor Use Only* section is to be completed, signed and dated by center or sponsor staff. The sponsor/center representative must review the income eligibility form and ensure that it is completed as indicated in the instructions above. Then indicate the following:

The CACFP Agreement Number.

Total Number of Household Members – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in child care and the number of foster children, if applicable.

Total Household Income – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the form must be categorized as *paid.*

Number of Free, Reduced or Paid – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced** or **Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete forms (missing signatures, income information, last four digits of Social Security Number or SNAP, TANF or FDPIR numbers) are categorized in the paid category.

The income eligibility form is valid until the last day of the month one calendar year from the date it is signed by the household member. For example, a form signed on May 12, 2014 is valid until May 31, 2015.

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