My Recruiter's Name: ____________________

Phone: (212) 529-5252

E-Mail: camprecruiter@hfhnyc.org

Application Checklist

☐ **Registration Form**

Complete: Child's and Parents Information, session applying for, PA/SNAP number, Emergency Contacts, Parent/Legal Guardian Signature, Date

☐ **Health Form**

Pages 1-3 to be completed by the Parent/ Legal Guardian

- **Page 1**: Child and parent/Legal Guardian Information and child health insurance information, parent signature and date
- **Page 2:** List any restrictions. If none write 'n/a.' Answer all the 'General Questions.'
- **Page 3**: Allergies and Medication:
  - List any allergies and check any over-the-counter medication that we can give your child for common illness such as stomach ache, headache or colds.
  - Indicate if child takes any medication regularly and include doses and frequency
- **Pages 4 and 5 to be completed by child's doctor or clinic.**
  - Signature of the medical personnel can be waived if your child completed a physical on/after January 2017. A copy of the examination must be submitted.

☐ **Background Information Form:**

Note: The more information you provide us about your child, the better we can best serve his/her needs.

☐ **Summer Food Service Program Income Eligibility Form**

- If you have a PA or SNAP number complete Part one (name of child and PA or SNAP number) then skip to Part Four.
- If you do not have a PA/ SNAP Number, you must complete Part 3 listing the members of your household and your total household income.
- **EVERYONE** must complete Part 4 and 5

Document Checklist

A copy of the following documents can be prepared ahead of time!

☐ Copy of Child's PA/SNAP (Benefits) Card
☐ Copy of Child's Medicaid/Insurance Card (Child must have Health Insurance to go to camp)
☐ Copy of Child's Immunization Records/Electronic Medical Records
☐ Copy of Child's **Physical Examination** if **completed on/after January 2017 can be included to waive signature of a Licensed Medical Professional on pages 4 and 5 of the Health Form (green)**. **Otherwise** pages 4 and 5 must be completed, signed and dated by Licensed Medical Professional.

Session Dates

During Summer 2017, we will be operating three camp sessions. Each session last two weeks and you can indicate your session preference, however be aware that availability is filled in the order we received the completed applications, so we can't always guarantee a spot for the session of your choice.

- **Session 1:** Friday June 30, 2017 – Thursday July 13, 2017 (**Application Deadline: Wednesday June 14**)
- **Session 2:** Tuesday July 18, 2017 – Tuesday August 1, 2017 (**Application Deadline: Wednesday July 5**)
- **Session 3:** Monday August 7, 2017 – Monday August 21, 2017 (**Application Deadline: Wednesday July 26**)

Please keep a copy of your application for your records. Once we have received the completed application and we have assigned a session to your child, you will receive a Parent Letter with important information regarding how to prepare for camp.

HFH Summer Camps
WAKONDA LANOWA

Nombre De Su Reclutador:_______________

Telefono: (212) 529-5252

E-Mail: camprecruiter@hfhnyc.org

Instrucciones para Completar la Aplicación

☐ **Formulario de Registro:** Información sobre el menor y el padre/madre o guardián legal. No olvide indicar: Sesión a la que quiere aplicar; Numero de PA (Asistencia Pública) o SNAP/ Food Stamps (programa de alimentación); al menos dos contactos de emergencia (diferentes al padre/madre encargado); Y firmar!

☐ **Formulario de Saludb** La página 1-3 han de ser completadas por el Padre/ Madre o Guardián Legal. Página 4 y 5 por un profesional médico licenciado.

- **Página 1** No olvide su información de contacto y de seguro médico; FIRME e Indique fecha.
- **Pagina 2** Indique restricciones físicas y alimenticias del menor, si no tiene indique no; complete el historial médico marcando las condiciones que aplican.
- **Pagina 3** Indique alergias y marque las medicinas que podemos suministrar a su hijo para enfermedades comunes como la gripa, dolor de cabeza o dolor de estómago; Para medicamentos que su menor toma regularmente, indique nombre, dosis y frecuencia - Usted ha de proporcionarnos dos semanas de dicha prescripción.
- **Página 4 y 5 – PARA SER COMPLETADA, FIRMADA Y FECHADA POR UN PROFESIONAL MEDICO LICENSIADO.** Las páginas 4 y 5 pueden ser omitidas si usted incluye una copia de un examen físico general de su menor, realizado desde Enero 1, 2017 y usted nos proporciona una copia.

☐ **Entrevista Preliminar: Conteste** estas preguntas para que nuestros consejeros y Directores del Campamento puedan atender adecuadamente cualquier necesidad especial que tenga su hijo/hija.

☐ **Formulario Para Determinar Elegibilidad al Programa Especial de Alimentación de Verano**

- **En la parte 1**. Escriba el nombre del menor y su número de PA (Asistencia Pública), SNAP (Food Stamps- programa de alimentación). **Luego continúe con la parte 4** (su firma, nombre, fecha, dirección y los últimos cuatro dígitos de su número de seguro social- si lo tiene) **y parte 5**
- **Si no tiene un número de PA o de SNAP entonces ha de completar la parte 3.** Escriba los nombres de todos los miembros de su hogar y cualquier tipo de salarios o entradas monetarias que tenga dicho individuo. **Luego continúe con las partes 4 y 5** como se indica arriba.

LISTA DE DOCUMENTOS

Usted va a necesitar copias de los siguientes documentos:

☐ Copia del carnet de beneficios o asistencia pública (PA y SNAP) PA/SNAP

☐ Copia de la tarjeta de seguro médico del menor (todos los menores han de tener seguro médico para poder asistir al campamento)

☐ Copia del carnet de Inmunización/ vacunación de su menor

☐ **Si su menor ha tenido un Examen médico General a partir del 1ro de Enero del 2017 incluya una copia de este** Si no, lleve las páginas 4 y 5 del formulario de salud a su doctor o clínica de salud para ser completadas y firmadas.

Sesiones

Los cupos se distribuyen según se reciban las aplicaciones en su totalidad. No podemos garantizar cupo en la sesión de su preferencia. En dicho caso se le ofrecerá la sesión disponible:

- **Sesión 1:** - Viernes Junio 30, 2017 –Jueves Julio 13, 2017 (Fecha límite de aplicación: Miércoles Junio 14)
- **Sesión 2:** - Martes Julio 18, 2017 – Martes Agosto 1, 2017 (Fecha límite de aplicación: Miércoles Julio 5)
- **Sesión 3:** - Lunes Agosto 7, 2017 – Lunes Agosto 21, 2017(Fecha límite de aplicación: Miércoles Julio 26)

Guarde una copia de su aplicación. Una vez hayamos recibido y procesado su aplicación, usted recibirá una Carta de aceptación e información sobre cómo prepararse para el campamento.

HFH Summer Camps
WAKONDA LANOWA

Session preference is not guaranteed until approved.

☐**S1**: Jun 30 – Jul 13
☐**S2**: Jul 18 – Aug 1
☐**S3**: Aug 7 – Aug 21

HFH Camper Registration Form

Child's Last Name: ________________________________ **Child's First Name**:________________________________

Address: ____ Apt.: ________ Borough: _____________ Zip: ____________

Date of Birth: _____________ Current Age: _______ Gender: ☐ M ☐ F Status: ☐ New ☐ Returning

School:_________________________ Current Grade: _______ Language: ☐ English ☐ Spanish ☐ O: ________________

Parent/Guardian's Last Name:______________________________ **First Name:**______________________________

Relationship to Child: _______________________________ **Active TANF/Snap Number**: ________________________

Primary Phone: _______________________________________ Cell Phone: ___________________________________

Email: ____ Language: ☐ English ☐ Spanish ☐ O: _________________

FAMILY INFORMATION: (Check and fill all that apply)

☐ Currently in shelter: ____
(*Name of shelter and the month and year you started residence)*

☐ Previously in shelter: ____
(*Name of shelter & month and year you were discharged from residence)*

☐ Never in shelter ☐ HFH Program Participant: ____ PFI ____ SFI ☐ Agency: _______________________________

☐ Referred by DOE STH: ________________________ (*Borough)* Name: ____________________________________ *(Liaison)*

Name of Case Manager: ___________________________________ Phone No.:________________________________

EMERGENCY CONTACTS

Important: if we are unable to reach you, we will call your child's emergency contact.

Name (*NOT Parent/ Guardian listed above*)	**Relationship**	**Phone number**
1.		
2.		

PARENT/GUARDIAN SIGNATURE

1. I permit my child to attend Homes for the Homeless Summer Camps, and use transportation (e.g. bus or van) supplied by the program.
2. I agree to give Homes for the Homeless Summer Camps and/or its affiliates and/or program partners permission to use any materials and pictures and/or videos in which my child might appear, as well as artwork or writing my child produces, to help publicize the camp.
3. I permit Homes for the Homeless Summer Camps to provide routine and emergency health care, dispense medications, and seek medical or dental treatment for my child, as needed, while he or she is away; I consent to the release of any medical or other records necessary for treatment, referral, billing, or insurance purposes to Homes for the Homeless Summer Camps or other medical personnel treating my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to use the proceeds of whatever hospitalization or medical coverage my child may have in case of illness or accident
4. I permit Homes for the Homeless Summer Camps to call the case manager noted above if consultation is needed.
5. I permit my child to participate in camp activities, such as those described in the Parent Letter. I also permit my child to use camp-provided transportation and to participate in out-of-camp excursions such as overnights; hikes and special field trips (e.g. trip to the zoo).
6. If my child is going to camp, I confirm that I have read, or have had explained to me, the enclosed information about meningitis vaccination. If I choose not to have my child vaccinated, I confirm that I understand the risk of not receiving the vaccine.

SIGNATURE OF PARENT/LEGAL GUARDIAN:______________________________ **DATE**:______________________

For Camp Use Only: Camp:__________ Cabin:__________ Unit:__________ Session:__________

HFH Summer Camps
WAKONDA LANOWA

american CAMP association ACCREDITED

For Camp Use Only: Camp: ______ Cabin: ______ Unit: ______ Session: ______

MEDICAL: Health History and Examination Form

To Parent/ Guardian: Complete page 1 – 3 and submit with Physical Examination From to your physician for review.

Child's Last Name: ____________________________ **Child's First Name**:_________________________ **MI**:______

Address: _______________________________________ Apt #: _______ Borough: _____________ Zip: ______________

Custodial Parent/guardian Full Name:___________________________________ Phone:_________________________

Address: _______________________________________ Apt #: ________ Borough: _____________ Zip: ______________
(If different from above)

EMERGENCY CONTACTS: If we are unable to reach you we woll call your child's emergency contacts.

Name: _____________________________________ Relationship: ______________ Phone: ______________________

Name: _____________________________________ Relationship: ______________ Phone: ______________________

MEDICAL INSURANCE INFORMATION: All campers must have health insurance to attend HFH Summer Camps.

➔ **Please include a copy of your child's insurance card and/or benefits card.**

Does Medicaid/family medical/hospital insurance cover your child? ☐ Yes ☐ No

☐ Yes 11-digit Medicaid access no. __ __ __ __ __ __ __ __ __ __ __ Medicaid Sequence No. __ __

☐ No Name of Insured: _________________________________ Insurance Co.:______________________________

Group or Policy#: _______________________________ Carrier Phone Number:______________________

PARENT/GUARDIAN AUTHORIZATIONS

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I give permission to Homes for the Homeless Summer Camps medical staff to provide the above mentioned non-prescription medications as needed.

Permission for Camper to Carry and Use Sunscreen:

I give permission for my child to carry sunscreen and self apply sunscreen. I understand that the following conditions must be met in order to promote proper and safe use of sunscreen at camp: (1) The sunscreen will only be used to prevent overexposure to the sun. (2) Only sunscreen is approved by the FDA for over-the counter use will be permitted for use by camper. **Initials:**___________. If my child is unable to physically apply sunscreen themselves, I give permission for the camp staff to assist in the application of the sunscreen when directed to do so by my child. **Initials**: __________.

Permission to Provide Necessary Treatment or Emergency Care:

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of Parent/Legal Guardian: _________________________________ **Date:** ________________

If for religious reasons you cannot sign this form, contact the camp for a legal waiver, which must be signed for attendance.

RESTRICTIONS

Dietary:

- ☐ Does not eat red meat
- ☐ Does not eat pork
- ☐ Does not eat eggs
- ☐ Does not eat poultry
- ☐ Does not eat seafood
- ☐ Gluten Intolerance
- ☐ Does not eat dairy products
- ☐ Other: ________________

Please explain: ____

____

Activity:

Explain any physical limitations: ____

____

Behavioral, Emotional & Social Limitations:

Has you child ever been seen by a therapist/psychiatrist/mental health professional/counselor? ☐ **Y** ☐ **N** **If 'Y' explain**

Has your child ever been diagnosed with and/or have been treated for any of the following:

- ☐ ADD or AD/HD
- ☐ Anxiety
- ☐ Autism Spectrum Disorder (PDD etc.)
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Eating Disorder
- ☐ PTSD
- ☐ Speech or language impairment
- ☐ Other:________________________

Please explain: ____

____

GENERAL QUESTIONS

Please check "Y" or "N" for each question. Has/does your child:

Question	Y/N	Question	Y/N
1. Had any recent injury, illness, or infectious diseases?	☐ **Y** ☐ **N**	**11.** Ever had seizures?	☐ **Y** ☐ **N**
2. Have a chronic or recurring illness/condition?	☐ **Y** ☐ **N**	**12.** Ever had high blood pressure?	☐ **Y** ☐ **N**
3. Ever been hospitalized?	☐ **Y** ☐ **N**	**13.** Ever been diagnosed with a heart mumur?	☐ **Y** ☐ **N**
4. Ever had surgery?	☐ **Y** ☐ **N**	**14.** Ever had back or joint problems?	☐ **Y** ☐ **N**
5. Have frequent headaches?	☐ **Y** ☐ **N**	**15.** Have any skin problems (e.g., rash, acne)?	☐ **Y** ☐ **N**
6. Ever had a head injury or been knocked unconscious?	☐ **Y** ☐ **N**	**16.** Have diabetes?	☐ **Y** ☐ **N**
7. Wear glasses, contacts, and protective eyewear?	☐ **Y** ☐ **N**	**17.** Have asthma?	☐ **Y** ☐ **N**
8. Ever had frequent ear infections?	☐ **Y** ☐ **N**	**18.** Had mononucleosis in the past 12 months?	☐ **Y** ☐ **N**
9. Ever passed out during or after exercise?	☐ **Y** ☐ **N**	**19.** Had problems with diarrhea/constipation?	☐ **Y** ☐ **N**
10. Ever had dizziness or chest pain during or after exercise?	☐ **Y** ☐ **N**	**20.** If female, have an abnormal menstrual history?	☐ **Y** ☐ **N**

Explain "Y" answers:____

____

____

For Camp Use Only: Camper Name:__________ Camp:__________ Cabin:__________ Unit:__________ Session:__________

ALLERGIES

Does your child have allergies? ☐ **Y** ☐ **N** Fill in what he/she is allergic to, the reaction and authorized management

Medication allergies: ______________________________

Food allergies: ______________________________

Other – insect stings, hay fever: ______________________________

Does your child require an Epi-pen: ☐ **Y** ☐ **N** If 'Y,' Epi-pen must be brought with you to camp.

NON-PRESCRIPTION MEDICATION

Homes for the Homeless Summer Camps has the following non-prescription medications available as needed at the camp infirmary. Please check 'Y' or 'N' next to all non-prescription medications that may be dispensed to your child at camp. Campers will be given the recommended dosage, which corresponds to their age and/or weight as per label instructions.

Medication	Symptoms Treated	Can be used	Comments
Tylenol	Headache, Aches, Cramps	☐ **Y** ☐ **N**	
Ibuprofen	Headache, Aches, Cramps	☐ **Y** ☐ **N**	
Cough Syrup	Cough	☐ **Y** ☐ **N**	
Cough Drops	Cough	☐ **Y** ☐ **N**	
Visine	Red, Irritated Eyes	☐ **Y** ☐ **N**	
Antifungal Cream/Spray	Itchy, Burning Feet	☐ **Y** ☐ **N**	
Pepto Bismol	Upset Stomach	☐ **Y** ☐ **N**	
Kaeopectate	Antidiarrheal	☐ **Y** ☐ **N**	
Maalox	Antacid	☐ **Y** ☐ **N**	
Rolaids	Antacid	☐ **Y** ☐ **N**	
Antihistamines	Allergy	☐ **Y** ☐ **N**	
Anbesol	Toothache	☐ **Y** ☐ **N**	
Triple Antibiotic Ointment	Abrasions/Cuts	☐ **Y** ☐ **N**	
Bengay	Sore Muscles	☐ **Y** ☐ **N**	
Chloraseptic Spray	Sore Throat	☐ **Y** ☐ **N**	
Solarcaine	Sunburn	☐ **Y** ☐ **N**	

Note: The camp infirmary **WILL NOT** give your child treatment you do not check off.

ROUTINE MEDICATION

Please list **ALL** medications (including over-the-counter/ non-prescription drugs) taken routinely.

☐ This person takes **NO** medication on a routine basis
☐ This person takes medications as follows:

Medication	Dosage	Frequency	Reason For Taking
1.			
2.			
3.			

IMMUNIZATIONS

➔ A copy of your child's **completed immunization records** must be submitted or have doctor fill in page 4

For Camp Use Only: Campers Name:________ Camp:________ Cabin:________ Unit:________ Session:________

HFH Summer Camps WAKONDA LANOWA

MUST BE COMPLETED, SIGNED AND STAMPED BY DOCTOR

For Camp Use Only:
Camp: ______
Cabin: ______
Unit: ______
Session: ______

MEDICAL: Physical Examination Form

Note: If your child completed a physical examination on/after Jan. 1, 2017, pg 4-5 will be waived. A copy of the signed and stamped exam MUST be submitted.

Child's Last Name:________________________________ Child's First Name: ________________________________

D.O.B:______________ Age:________ Gender: ☐ M ☐ F BP: ___________ Weight:___________ Height:_________

The applicant is under the care of a physician for the following conditions:

(List allergies,prescribed meal plan,dietary restrictions etc.)

____

____

Which of the following has the participant had a history of?

☐ ADD/ADHD ☐ Seizures ☐ Heart Disease ☐ Diabetes ☐ Lyme Disease ☐ Mood Disorder ☐ ODD

RECOMMENDATIONS AND RESTRICTIONS AT CAMP

Please list **ALL** medications (including over-the-counter/ non-prescription drugs) taken routinely.

☐ This person takes **NO** medication on a routine basis
☐ This person takes medications as follows:

Medication	Dosage	Frequency	Reason For Taking
1.			
2.			
3.			

IMMUNIZATION

Please give all dates of immunization for: (or attach photocopy of official record)

Vaccine	**Date:** MM/YY	MM/YY	MM/YY	MM/YY	MM/YY	MM/YY
DTP	______	______	______	______	______	______
DT (Diphtheria/Tetanus)	______	______	______	______	______	______
Polio	______	______	______	______	______	______
Tetanus	______	______	______	______	______	______
Hepatitis B	______	______	______			
Haemophilus Influenza B	______	______	______			
MMR	______	______				
Measles	______	______		Mumps	______	______
Rubella	______	______				
Varicella (chicken pox)	______	______				
Meningococcal (Meningitis)	______	______				
Human Papillomavirus (HPV)	______	______				
Hepatitis A (HEP A)	______	______				

MUST BE COMPLETED, SIGNED AND STAMPED BY DOCTOR

DISEASE HISTORY

ALL campers must provide the following information.

Which of the following illnesses has the participant had?

☐ Measles ☐ Chicken Pox ☐ German measles ☐ Mumps ☐ Hepatitis ☐ Varicella Zoster

TB Mantoux Test: Date of test:____________________ Result: ☐ Negative ☐ Positive

Describe any limitation or restriction on camp activities:____

Additional Comments:____

PHYSICIAN AUTHORIZATIONS

Name of child's physician:____ Phone:________________________

Address:____

Name of child's dentist:____ Phone:________________________

Address:____

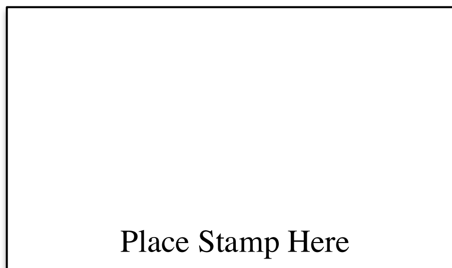
Physician's Statement:

"I have examined ____________________________________and discussed the child's health history with the child's
Print Child's Name

parent/guardian. In my opinion the above applicant is physically and emotionally fit to participate in an active camp program. I hereby give permission to Homes for the Homeless Summer Camps medical staff to provide the above mentioned prescription and/or non-prescription medications to this child as needed."

MANDATORY Printed:________________________________ **Signature of Physician:**________________________

Title:________________________________ Date of Examination:_____________________


Place Stamp Here

For camp use only

Screening Record

Date screened:____________________ Time:_______________am / pm Screened by____

Meds received____

Updated/additions to health history noted: Yes No None required

Current health needs identified:____

Observational notes:____

For Camp Use Only: Camp:______________ Cabin:______________ Unit:______________ Session:______________

Meningococcal Meningitis

This insert is for informational purposes only, and is referred to on the Registration Form of the child's application. Please read it carefully, and then keep this sheet for your own records.

Dear Parent,

I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and a new law in New York State. On July 22, 2003, the New York State Public Health Law (NYS PHL) was amended to include §2167 requiring overnight children's camps to distribute information about meningococcal disease and vaccination to the parents or guardians for all campers who attend camp for 7 or more nights. This law became effective on August 15, 2003.

Homes for the Homeless Summer Camps is required to maintain a record of the following for each camper:

- A response to receipt of meningococcal meningitis disease and vaccine information signed by the camper's parent or guardian; AND
- Information on the availability and cost of meningococcal meningitis vaccine (Menonmune™); AND EITHER
- A record of meningococcal meningitis immunization within the past 10 years; OR
- An acknowledgement of meningococcal meningitis disease risks and refusal of meningococcal meningitis immunization signed by the camper's parent or guardian.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation, and even death.

Cases of meningitis among teenagers and young adults ages 15 to 24 have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States—types A, C, Y, and W-135. These types account for nearly two thirds of meningitis cases amongst teenagers and young adults.

Information about the availability and cost of the vaccine can be obtained from your health care provider and by visiting the manufacturer's website at www.meningitisvaccine.com.

I encourage you to carefully review the enclosed materials. **As stated in the bullet points above we simply need to know that you are aware of meningococcal meningitis and then based on that knowledge have documented your decision to either decline or seek out the vaccination.**

To learn more about meningitis and the vaccine, please consult your child's physician. You can also find information about the disease on the Web sites of the New York State Department of Health, www.health.state.ny.us, and the Centers for Disease Control and Prevention, www.cdc.gov/ncidod/dbmd/diseaseinfo.

Sincerely,

HFH Summer Camps

HFH Summer Camps
WAKONDA LANOWA

Child's Name:____________________

Date of Birth: ____________________

Current Age: ______

Gender: ☐ M ☐ F

For Camp Use Only:
Camp:______________
Cabin:______________
Unit:______________
Session:______________

Background History

Answering 'Yes' to any of the following questions will not necessarily prevent your child from attending camp.

1. Does your child attend a special needs program or receive 1:1 aid in school?

☐ Yes ☐ NO If yes, please explains:____

2. Does your child know how to read and write?

☐ Yes ☐ NO If no, please explain:____

3. Does your child have any major health issues?

☐ Yes ☐ NO If yes, please describe:____

4. Does your child use words to express needs and feelings? If no, please explain how we can best communicate with them.

☐ Yes ☐ NO ____

5. If he/she struggles with attention, what do you do to focus them?

____

6. Does your child have any special fears (animals, dark, heights etc.)? ______________________

7. Does your child wander off from others? If yes, please explain (e.g. runs from group, sneak away)

☐ Yes ☐ NO ____

8. How does your child get along with other children? (taking turns, group activities, conflict, etc.)

____

9. Does your child have a history of: ☐ Bedwetting ☐ Sleep walking ☐ Difficulty falling asleep ☐ Nightmares

Explain:____

10. Has there been any significant change in your child's family in the last year?

☐ Divorce/Separation of Parents ☐ Moving ☐ Illness/Death ☐ New Sibling ☐ New School ☐ Other

Explain:____

11. Does your child have any difficulty with bowel or bladder control?

☐ Yes ☐ NO If yes, please describe:____

12. Will there be more than one child in your family attending the same camp together?

☐ Yes ☐ NO If yes, list names of siblings: ____

13. Has your child ever attended a sleep-away camp before? ☐ Yes ☐ NO List the camp and year:________________

14. Please check which of the following describes your child's personality.

☐ Friendly ☐ Follower ☐ Happy ☐ Aggressive ☐ Loud ☐ Stubborn ☐ Withdrawn/Shy ☐ Helpful ☐ Cooperative

15. List any other valuable information HFH Camp staff should be aware of to ensure your child has a fun and safe experience:

____

INCOME ELIGIBILITY FORM
FOR THE
SUMMER FOOD SERVICE PROGRAM
(For Use by Camps and Closed Enrolled Sites)

Please complete the following form using the instructions below. Sign the form and return it to: **[Name of Sponsor]**
____.

If you need help, call **[phone number of Sponsor]**

Follow these instructions, if your household gets SNAP (Food Stamps) TANF or FDPIR:

Part 1: List participant's name and a SNAP (Food Stamp), TANF or FDPIR case number.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Sign the form. A Social Security Number is NOT required.
Part 5: Answer this question if you choose to.

If your household includes a FOSTER CHILD, use one application for the whole household and follow these instructions:

Part 1: Enter the child's name.
Part 2: Please contact us at **[phone number of Sponsor]**
Part 3: Complete this part if you are applying for other children in the household and you did not enter a SNAP (Food Stamp), TANF or FDPIR case number in Part 1.
Part 4: Sign the form. If Part 3 was completed, provide the last four digits of the signing adult's Social Security Number.
Part 5: Answer this question if you choose to.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List each participant's name.
Part 2: Skip this part.
Part 3: Follow these instructions to report total household income from last month.

Column A–Name: List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B–Gross income last month and how often it was received. Next to each person's name, list each type of income received last month, and how often it was received.

In Box 1, list the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).

In box 2, list the amount each person got last month from welfare, child support, alimony.

In box 3, list Social Security, pensions, and retirement.

In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.

Column C–Check if no income: If the person does not have any income, check the box.

Part 4: An adult household member must sign the form and include the last four digits of his or her Social Security Number, or mark the box if he or she doesn't have one.
Part 5: Answer this question if you choose to.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Part 1. Children enrolled in Camp or Closed Enrolled Sites.	
Names (First, Middle Initial, Last)	SNAP (Food Stamp), TANF or FDPIR case # (if any). **Skip to Part 4 if you listed a case #.**

Part 2. Foster Child

Foster children eligible for free and reduced-price meals regardless of household income. If a foster child lives with you, please contact **[name of Sponsor]** at **[phone number]**. Complete Part 3 if you are applying for other children in your household and you did not enter a SNAP (Food Stamp), TANF or FDPIR case number in Part 1.

Part 3. Total Household Gross Income—You must tell us how much and how often

A. Name (List **everyone** in household, including children)	**B. Gross income and how often it was received** *Example: $100/monthly $100/twice a month $100/every other week $100/weekly*				**C. Check if NO income**
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement,	4. All Other Income	
1.	$______/________	$______/_______	$______/_______	$______/_______	❑
2.	$______/________	$______/_______	$______/________	$______/_______	❑
3.	$______/________	$______/_______	$______/________	$______/_______	❑
4.	$______/________	$______/_______	$______/________	$______/_______	❑
5.	$______/________	$______/_______	$______/________	$______/_______	❑
6.	$______/________	$______/_______	$______/________	$______/_______	❑
7.	$______/________	$______/_______	$______/________	$______/_______	❑
8.	$______/________	$______/________	$______/________	$______/________	❑
9.	$______/________	$______/________	$______/________	$______/________	❑
10.	$______/________	$______/________	$______/________	$______/________	❑
11.	$______/________	$______/________	$______/________	$______/________	❑
12.	$______/________	$______/_______	$______/________	$______/_______	❑

Part 4. Signature and Social Security Number (Adult must sign)

An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the “I do not have a Social Security Number” box. (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that this information is being given for the receipt of Federal funds. I understand that SFSP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: X________________________________Print name:_______________________________Date: ______________

Address:____Phone Number:________________________

Last four digits of Social Security Number: __ __ __ __ ❑ I do not have a Social Security Number

Part 5. Participant’s ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Asian ❑ White ❑ Black or African American	❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander

Don’t fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____________ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year

Household size: ________

Categorical Eligibility: ___ Date Withdrawn: ________ Eligibility: Free___ Reduced___ Denied___

Reason: ____

Determining Official’s Signature: ____ Date: ______________

Confirming Official’s Signature: ____ Date: ______________

Follow-up Official’s Signature: ____ Date:______________