HFH Summer Camps
WAKONDA
LANOWA

Ask for a Camp Recruiter

Phone: (212) 529-5252

Fax: 212.529.7698

Application Checklist

☐ **Registration Form**

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

- **Bus authorization form:** Parents/Legal Guardian must fill out this form authorizing or not authorizing another adult to pick up/drop off their child at the bus locations.

☐ **Medical Form**

PART A be completed by the Parent/ Legal Guardian

- **Page 1**: Child and Parent/Legal Guardian Information and child health insurance information, Medication: Indicate if child takes any medication regularly and include doses and frequency
- **Page 2:** List any restrictions. If none write 'n/a.' Answer all the 'General Questions'
- **Page 3**: Allergies and authorizations
  - 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.
  - Initial each authorization, sign and date. If you can not sign this form due to religious reasons, please contact the central office for a legal waiver.

PART B to be completed by the Child's Doctor or Clinic

- The doctor or clinic must complete our Medical Physical Examination form. The physical examination must have been conducted on/after June 1, 2017.

☐ **Meningococcal Meningitis Vaccination Response Form**

- Information about the Meningococcal Meningitis virus. Parents please complete the response form stating your child has or has not received the vaccination

☐ **Background Information Form**

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

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

- If you have a PA or SNAP number complete Part 1 (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 every member of the household (including children) 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

Session Dates

During Summer 2018, we will be operating three camp sessions. Each session lasts two weeks. You can indicate your session preference, however, availability is filled in the order we receive completed applications, so we can't always guarantee a spot for the session of your choice.

- **Session 1:** Thursday June 28, 2018 - Wednesday July 11, 2018
  (Application Deadline Thurs. June 14th)

- **Session 2:** Monday July 16, 2018 - Monday July 30, 2018
  (Application Deadline Mon. July 2nd)

- **Session 3:** Friday August 3, 2018 - Friday August 17, 2018
  (Application Deadline Fri. July 20th)

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.

Contact Information

Phone: (212) 529-5252

Fax: 212.529.7698

HFH Summer Camps
WAKONDA
LANOWA

Pregunte por un reclutador de campo

Teléfono: (212) 529-5252

Fax: 212.529.7698

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 (Cupones de Alimentos); al menos dos contactos de emergencia (diferentes al padre/madre encargado); Y firmar!

- Formulario de autorización de autobús: Los padres deben llenar este formulario autorizando o no autorizando a otro adulto a recoger / dejar a su hijo en las ubicaciones del autobús.

☐ Formulario de Salud

PARTE A han de ser completadas por el Padre/ Madre o Guardián Legal.

- **Página 1:** Información sobre niños y padres / tutores legales y seguro de salud infantil.
  Medicamentos: Indique si el niño toma algún medicamento con regularidad e incluya dosis y frecuencia.
- **Página 2:** enumere las restricciones. Si ninguno escribe 'n / a'. Responda todas las 'Preguntas generales'
- **Página 3:** Alergias y autorizaciones
  - Haga una lista de todas las alergias y verifique cualquier medicamento de venta libre que podamos darle a su hijo para enfermedades comunes tales como dolor de estómago, dolor de cabeza o resfriados.
  - Inicialice cada autorización, firma y fecha. Si no puede firmar este formulario por razones religiosas, comuníquese con la oficina central para obtener una exención legal.

PARTE B será completado por médico o clínica

- El médico o la clínica deben completar nuestro formulario de examen físico médico. El examen físico debe se han realizado después del 01 de junio de 2017

☐ Formulario de respuesta de vacunación Meningitis Meningocócica

- información sobre el virus de la Meningitis Meningocócica. Padres por favor completan el formulario de respuesta que el niño tiene o no ha recibido la vacunación

☐ 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 (Cupones de Alimentos). Tiene que 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 tienes un PA / número de SNAP, usted debe completar parte 3 Listado de todos los miembros de la familia (incluyendo niños) y su ingreso total del hogar.
- **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 de la tarjeta 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 Inmunización/ vacunación de su menor

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:** Jueves, Junio 28, 2018 – Miércoles, Julio 11, 2018
  (Fecha límite de aplicación: Jueves, Junio 14)

- **Sesión 2:** Lunes, Julio 16, 2018 – Lunes, Julio 30, 2018
  (Fecha límite de aplicación: Lunes, Julio 2)

- **Sesión 3:** Viernes, Augusto 3, 2018 – Viernes, Augusto 17, 2018
  (Fecha límite de aplicación: Viernes, Julio 20)

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.

Información de Contacto

Teléfono: (212) 529-5252

Fax: 212.529.7698

HFH Summer Camps
WAKONDA LANOWA

HFH Camper Registration Form

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

Child Information

Last Name: _____ **First Name:** _____

Address: _____ **Apt.**: _____ **Borough:** _____ **Zip:** _____

Date of Birth: _____ **Current Age:** _____ **Gender:** ☐ M ☐ F **Language:** ☐ English ☐ Spanish ☐ O: _____

Current Grade: _____ **School:** _____ **Attended HFH Summer Camps before:** ☐ Yes ☐ No

Parent/Guardian Information

Last Name: _____ **First Name:** _____

Relationship to Child: _____ **Active TANF/SNAP Number:** _____

Primary Phone: _____ **Cell Phone:** _____

Email: _____ **Language:** ☐ English ☐ Spanish ☐ O: _____

Session Preference (not guaranteed until approved)

☐ **S1: Jun 28 – July 11** ☐ **S2: Jul 16 – July 30** ☐ **S3: Aug 3 – Aug 17**

Household 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)*

Name of Case Manager: _____ **Phone No.:** _____

☐ **HFH Program Participant (Afterschool/Recreation):** _____ Prospect _____ Saratoga

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.		

Parental Consent

1. I permit my child to attend HFH Summer Camps and use transportation (e.g. bus or van) supplied by the program.
2. I agree to give HFH 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 HFH 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 HFH Summer Camps or other medical personnel treating my child. In the event that I cannot be reached during an emergency, I hereby give permission to the physician treating my child to use whatever treatment they deem medically necessary to treat my child in the event of an emergency or in need of medical care.
4. I permit HFH 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**: _____

HFH Summer Camps
WAKONDA LANOWA

HFH Camper Registration Form

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

Child Information

Last Name: _____ **First Name:** _____

Address: _____ **Apt.:** _____ **Borough:** _____ **Zip:** _____

Date of Birth: _____ **Current Age:** _____ **Gender:** ☐ M ☐ F **Language:** ☐ English ☐ Spanish ☐ O: _____

Current Grade: _____ **School:** _____ **Attended HFH Summer Camps before:** ☐ Yes ☐ No

Parent/Guardian Information

Last Name: _____ **First Name:** _____

Relationship to Child: _____ **Active TANF/SNAP Number:** _____

Primary Phone: _____ **Cell Phone:** _____

Email: _____ **Language:** ☐ English ☐ Spanish ☐ O: _____

Session Preference (not guaranteed until approved)

☐ **S1: Jun 28 – July 11** ☐ **S2: Jul 16 – July 30** ☐ **S3: Aug 3 – Aug 17**

Household 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)*

Name of Case Manager: _____ **Phone No.:** _____

☐ **HFH Program Participant (Afterschool/Recreation):** _____ Prospect _____ Saratoga

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.		

Consentimiento de los Padres

1. Permito a mi hijo asistir a campamentos de verano de HFH y utilizar el transporte (p. ej. bus o van) suministrados por el programa.
2. Estoy de acuerdo en dar a campamentos de verano de HFH, sus afiliados o programa de socios permiso de usar cualquier material y fotos o videos en los que mi hijo puede aparecer, así como obra de arte o escritura que mi hijo produce, para ayudar a dar a conocer el campo.
3. Permito a campamentos de verano HFH proporcionar rutina y asistencia médica de emergencia, dispensar medicamentos y buscar tratamiento médico o dental para mi hijo, cuando sea necesario, mientras que él o ella está lejos. Doy mi consentimiento para la publicación de cualquier médico u otros documentos necesarios para el tratamiento, remisión, facturación, o efectos del seguro a campamentos de verano de HFH u otro personal médico tratamiento de mi hijo. En caso de que yo no puedo ser alcanzado durante una emergencia, por la presente doy permiso al médico tratar a mi hijo para utilizar cualquier tratamiento consideren médicamente necesarios para el tratamiento de mi hijo en caso de emergencia o necesidad de atención médica.
4. Permito campamentos de verano de HFH llame al administrador del caso indicado arriba si se necesita una consulta.
5. Permito a mi hijo a participar en actividades de campo, tales como los descritos en la carta de los padres. También permiten a mi hijo a utilizar el transporte proporcionado por el campo y participar en excursiones, fuera del campamento como alojamiento; excursiones y especiales del campo viajes (p. ej. visita al zoológico).
6. Si mi hijo va al campo, confirmo que he leído, o han tenido me explicó, la información adjunta sobre la vacunación de meningitis. Si no decido que mi hijo la vacuna, confirmo que entiendo el riesgo de no recibir la vacuna

SIGNATURE OF PARENT/LEGAL GUARDIAN: _____ **DATE**: _____

HFH Summer Camps
WAKONDA LANOWA

Pick up/Drop-off Authorization Form for the 2018 Camp Season

Please fill out Part 1 if you authorize an adult 18 yrs. or older to pick up/drop off your child at their assigned bus locations
Please **only** fill out Part 2 if you **do not** authorize anyone else to pick up or drop off your child.

Part 1

I, _____ (Print Parent/Guardian name) authorize those indicated below to

pick up and drop off _____ (Print Child's name), at my child's assigned bus location for his/her 2018 HFH Summer Camp Session.

Parent Signature _____ Date _____

Name: _____ Relationship to child: _____

Phone: _____

Name: _____ Relationship to child: _____

Phone: _____

Name: _____ Relationship to child: _____

Phone: _____

Part 2

☐ Please check here if you **do not** authorize anyone but yourself

I, _____ (Print Parent/Guardian name), do not authorize anyone else to pick up or

drop off my child _____ (Print Child's name) for his/her 2018 HFH Summer Camp Session.

Parent Signature: _____ Date: _____

HFH Summer Camps
WAKONDA LANOWA

american camp association ACCREDITED

MEDICAL FORM PART A

To Parent/ Guardian: Complete pages 1 – 3

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 will 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:_____

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:

Name of Medication	Dosage	When it is given	Reason For Taking
1.		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:	
2.		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:	
3.		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:	

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

RESTRICTIONS

Dietary:

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

Please explain: _____

_____

Activity:

Explain any physical limitations: _____

_____

Behavioral, Emotional & Social Limitations:

Has your 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 ☐ Bipolar Disorder ☐ PTSD
☐ Anxiety ☐ Depression ☐ Speech or language impairment
☐ Autism Spectrum Disorder (PDD etc.) ☐ Eating Disorder ☐ Other:_____

Please explain: _____

_____

GENERAL QUESTIONS

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

1. Had any recent injury, illness, or infectious diseases?	☐ **Y** ☐ **N**	**11.** Ever had seizures? If yes, Last attack date:	☐ **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 murmur?	☐ **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? If yes, Last attack date:	☐ **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 – (Example: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

HFH 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 if you do not check off any of the medication.

PARENT/GUARDIAN AUTHORIZATOINS

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

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 HFH Summer Camps medical staff to provide the 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 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 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:** _____

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

HFH Summer Camps
WAKONDA LANOWA

Information about the Meningococcal disease

Dear Parent:

I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningococcal meningitis. New York State Public Health Law (NYS PHL) §2167 and Subpart 7-2 of the State Sanitary Code requires overnight children's camps to distribute information about meningococcal disease and vaccination to all campers who attend camp for 7 or more consecutive nights.

HFH Summer Camps is required to maintain a record for each camper, signed by the camper's parent or guardian, which documents the following:

- A response to receipt of meningococcal disease and vaccine information;
  AND EITHER
- A record of meningococcal meningitis immunization; OR
- An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization.

Meningococcal disease is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. Meningococcal disease can cause serious illness such as infection of the lining of the brain and spinal column (meningitis) or blood infections (sepsis). The disease strikes quickly and can lead to severe and permanent disabilities, such as hearing loss, brain damage, seizures, and limb amputation, in as many as one in five of those infected. Ten to 15 percent of those who get meningococcal disease will die.

Meningococcal disease can be easily spread from person-to-person by coughing, sharing beverages or eating utensils, kissing, or spending time in close contact with someone who is sick or who carries the bacteria. People can spread the bacteria that cause meningococcal disease even before they know they are sick.

Anyone can get meningococcal disease, but certain people are at increased risk including teens and young adults 16 – 23 years old and those with certain medical conditions that affect the immune system.

The single best way to prevent meningococcal disease is to be vaccinated. The meningococcal ACWY (MenACWY) vaccine protects against four major strains of bacteria, which cause about two-thirds of meningococcal disease in the United States. The Centers for Disease Control and Prevention (CDC) recommends a single dose of MenACWY vaccine at age 11 through 12 years with a booster dose given at age 16 years. The meningococcal B (MenB) vaccine protects against a fifth strain of meningococcal bacteria, which causes about one-third of meningococcal disease. Young adults aged 16 through 23 years may be vaccinated with MenB vaccine and should discuss the MenB vaccine with a healthcare provider.

Information about the availability and cost of the vaccine can be obtained from your health care provider or your local health department.

I encourage you to carefully review the attached Meningococcal Disease Fact Sheet. **The form must be filled out and returned to the Central office before the start of your child's camp session**

To learn more about meningitis and the vaccine, please feel free to contact HFH Summer Camps at 212.529.5252 and/or consult your child's physician. You can also find information about the disease at the website of the Centers for Disease Control and Prevention: www.cdc.gov/vaccines/vpd-vac/mening/default.htm.

Sincerely,

HFH Summer Camps

HFH Summer Camps
WAKONDA LANOWA

MENINGITIS VACCINATION
RESPONSE FORM

New York State Public Health Law requires that a parent or guardian of campers who attend an overnight children's camp for seven (7) or more consecutive nights, complete and return the following form to the camp.

Check one box and sign below:

□ My child has received meningococcal immunization (Menactra or Menveo) within the past 10 years.

Date received: _____

[Note: The Centers for Disease Control and Prevention recommend two doses of MenACWY vaccine (Brand names: Menactra, Menveo) for all adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at 16 years of age. Adolescents in this age group with HIV infection should get three doses: 2 doses at least 8 weeks apart at 11 or 12 years of age, plus a booster dose at 16 years of age.

If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18 years of age. If the first dose (or series) is given after the 16th birthday, a booster is not needed.

Young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series (Brand names: Trumenba, Bexsero). Parents/guardians should discuss the Meningococcal B vaccine with a healthcare provider.]

□ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will not obtain immunization against meningococcal disease.

Signed: _____ Date: _____
(Parent / Guardian)

Camper's Name: _____ Date of Birth: _____

Mailing Address: _____

Parent/Guardian's E-mail Address (optional): _____

Phone Number: _____

HFH Summer Camps WAKONDA LANOWA

MUST BE COMPLETED, SIGNED AND STAMPED BY DOCTOR

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

MEDICAL FORM PART B

A doctor MUST complete Medical Form Part B. The physical examination must have been conducted on or after June 1, 2017

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

D.O.B.:_____ **Age:**___ **Gender**: ☐ M ☐ F **Weight**:_____**Height**:_____ **Blood Pressure**:__/___

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

Does the child have Asthma ☐ Yes ☐ No If *yes,* ☐ Intermittent ☐ Mild persistent ☐ Moderate persistent ☐ Severe persistent

Does the child have an Asthma Action Plan? ☐ Yes ☐ No Please *provide a copy or complete the action plan attached*

ROUTINE MEDICATION

"Medication" is any substance a person takes to maintain and/or improve their health. Please list ALL medications taken routinely.

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

Name of medication	Dosage	Frequency	Diagnosis/ Comment
1.		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:	
2.		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:	
3.		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:	

RESTRICTIONS AT CAMP

This child can participate in all physical activities, including swimming? ☐ Yes ☐ No

Does this child have any restrictions, physical limitations? ☐ None ☐ Yes

If yes, please explain: _____

Additional Comments: _____

_____

MUST BE COMPLETED, SIGNED AND STAMPED BY DOCTOR

IMMUNIZATIONS

Provide the month and year for each immunization. Starred (*) immunizations must include date to meet ACA Standard. Copies of immunization forms from health-care providers or state or local government are acceptable.

Immunization		Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTaP) or (TdaP)							
Tetanus booster* (dT) or (TdaP)							
Mumps, measles, rubella (MMR)							
Polio (IPV)							
Haemophilus influenzae type B (HIB)							
Pneumococcal (PCV)							
Hepatitis B							
Hepatitis A							
Meningococcal meningitis (MCV4)							
Varicella (chicken pox)	☐ Had chicken pox Date:						

Tuberculosis (TB) test	DATE:	☐Negative ☐ Positive

PHYSICIAN AUTHORIZATION

Name of child's physician:_____ Phone:_____

Address:_____

Physician's Statement:

"I have examined _____and discussed the child's health history with the child's 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:_____

HFH Summer Camps WAKONDA LANOWA

ASTHMA ACTION PLAN

Child's Name: _____ Date of Birth: _____
Doctor: _____ Doctor's Phone number: _____

****** To be determined by Physician Authorizing Treatment ******

Severity: ☐ Severe Persistent ☐ Moderate Persistent ☐ Mild Persistent ☐ Mild Intermittent

Green Zone: GO - You're Doing Well

Personal Best Peak Flow: _____	**Peak Flow From**	Medication	How Much	How Often / When
• Breathing is good • No Cough or wheeze **OR** • Sleep through the night • Can play and work	_____ **to** _____			

Yellow Zone: Caution - Slow Down! **Continue with green zone medicine and add:**

You may have any of these symptoms:	**Peak Flow From**	Medication	How Much	How Often / When
• First signs of a cold • Exposure to known trigger • Cough **OR** • Mild Wheeze • Tight chest • Coughing at night	_____ **to** _____			

Red Zone: Danger - Get Help! **Take These Medications and Call your Provider Now!**

Your Asthma is *getting worse* fast:	**Peak Flow less than**	Medication	How Much	How Often / When
• Medicine is not helping • Breathing is hard and fast • Nose opens wide **OR** • Ribs show • Can't talk well	_____			

Get help from a Doctor now! Do not be afraid of causing a fuss. It's Important! To go directly to the emergency room and bring this form. **DO NOT WAIT!**

Provider Signature: _____ Date: _____
(Required)

PARENT OR GUARDIAN TO COMPLETE THIS SECTION:

I **_____ (Print Parent/Guardian name)** give permission to the camp nurse/EMT to exchange information and otherwise assist in the asthma management of my child including direct communication with my child's primary care provider.

Parent / Guardian Signature: _____ Date: _____

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

HFH Summer Camps
WAKONDA LANOWA

Child's Name:_____

Date of Birth: _____

Current Age: _____

Gender: ☐ M ☐ F

Background Information Form

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 all of the following that describe your child

☐ 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:

_____

For Camp Use Only:

Camp: _____

Cabin: _____

Unit: _____

Session: _____

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: HFH Summer Camps

_____.

If you need help, call 212.529.5252

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:_____