HFH Summer Camps
Main Office

Phone: (212) 529-5252
Fax: (631) 551-1200

Application Checklist

☐ **Registration Form**
- You must complete and answer all questions on the registration form

☐ **Parental Consent Form**
- Form pertaining to parental consent and medical consent must be signed by a parental/ legal guardian.

☐ **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 stomachache, headache or colds.

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, 2019. **Please note all children must have all immunizations required for the child to attend school in NY State in order to attend camp. All campers must have MMR vaccination to attend camp, we must have documented the month, day and year the two shots were administered**

☐ **Meningococcal Meningitis Vaccination Response Form**
- Information about the Meningococcal Meningitis virus. Parents please complete the response form stating if 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 Parent/Guardian's PA/SNAP (Benefits) Card
- ☐ Copy of Child's Benefit Card/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 2020, we will be operating three camp sessions. Each session lasts one to 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:** Wednesday July 1, 2020 – Tuesday July 7, 2020 (7 days)
  (Application Deadline Wed. June 17th)

- **Session 2:** Tuesday July 14, 2020 - Monday July 27, 2020 (13 days)
  (Application Deadline Mon. June 30th)

- **Session 3:** Thursday July 30, 2020 - Thursday August 13, 2020 (14 days)
  (Application Deadline Fri. July 16th)

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

Camp Office: 212.529.5252 ask for a Camp Recruiter!

HFH Summer Camps
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Oficina Central del Campamento de Verano HFH

Phone: (212) 529-5252
Fax: (631)551-1200

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!
- El formulario relacionado con el consentimiento de los padres y el consentimiento médico debe ser firmado por un padre / tutor legal.
- 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 2018. **Tenga en cuenta que todos los niños deben tener todas las vacunas requeridas para que el niño asista a la escuela en el estado de Nueva York para poder asistir al campamento. Todos los campistas deben tener la vacuna MMR para asistir al campamento, debemos documentar el mes, el día y el año en que se administraron las dos vacunas.**

☐ 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

Durante el verano de 2020, estaremos operando tres sesiones de campamento. Cada sesión dura una o dos semanas. Puede indicar su preferencia de sesión, sin embargo, la disponibilidad se completa en el orden en que recibimos las solicitudes completas, por lo que no siempre podemos garantizar un lugar para la sesión que elija.

- **Sesión 1:** miércoles 1 de julio de 2020 - martes 7 de julio de 2020 (7 días)
  (Fecha límite de aplicación: miércoles 17 de junio)

- **Sesión 2:** martes 14 de julio de 2020 - lunes 27 de julio de 2020 (13 días)
- **(Fecha límite de aplicación: lunes 30 de junio)**

- **Sesión 3:** jueves 30 de julio de 2020 - jueves 13 de agosto de 2020 (14 días)
  (Fecha límite de aplicación: viernes 16 de julio)

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

La Oficina Central: 212.529.5252 pregunta por un reclutador de campamento.

HFH Summer Camps
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HFH Camper Registration Form

Child Information

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

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: _____

Resident at HFH Facility

☐ **Prospect Family Residence** ☐ **Williamsbridge Family Residence** ☐ **Saratoga Family Residence**

Case Manager's Name: _____

Session Preference (Not Guaranteed until Approved)

☐**S1: July 1st - July 7th (7 days)** ☐**S2: July 14th – July 27th (13 days)** ☐**S3: July 30th – August 13th (14 days)**

Household Information

Address: _____ **Apt:** _____ **City:** _____ **Zip:** _____

☐ **HFH Prospect Family Residence Afterschool Participant**

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.		

For staff use only:

Name of staff submitting application: _____

HFH Facility: _____

Department: _____

For Central office only:

Date received: _____ *initial:* _____

For Camp Use Only:

Cabin: _____

Unit: _____

Session: _____

HFH Summer Camps
WAKONDA LANOWA

HFH Summer Camps Formulario de consentimiento y liberación

For Camp Use Only:

Cabin:_____

Unit:_____

Session:_____

El siguiente formulario debe ser firmado por un padre legal. Si por motivos religiosos no puede firmar este formulario, comuníquese con la oficina central para obtener una exención legal, que debe estar firmada para asistir.

El nombre del niño: _____

Fecha de nacimiento del niño: _____

Como padre legal del niño mencionado anteriormente:

Permito a mi hijo asistir a campamentos de verano de HFH y utilizar el transporte (p. ej. bus o van) suministrados por el programa.

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.

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.

Permito campamentos de verano de HFH llame al administrador del caso indicado arriba si se necesita una consulta.

Estoy de acuerdo en que el campamementos de verano HFH no es responsable por la ropa o artículos perdidos o dañados que mi hijo trae con ellos a su sesión de campamento de verano.

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.

El siguiente formulario debe ser firmado por un padre legal. Si por motivos religiosos no puede firmar este formulario, comuníquese con la oficina central para obtener una exención legal, que debe estar firmada para asistir.

Como padre legal del niño mencionado anteriormente, el historial de salud proporcionado es correcto y completo, que yo sepa, y la persona que se describe aquí tiene permiso para participar en todas las actividades del campamento HFH Summer Camps, excepto en lo que se indica. Doy permiso al personal médico de HFH Summer Camps para proporcionar los medicamentos sin receta mencionados, según sea necesario.

Doy permiso para que mi hijo lleve protector solar y se aplique protector solar. Entiendo que se deben cumplir las siguientes condiciones para promover el uso adecuado y seguro de la protección solar en el campamento: (1) La protección solar solo se utilizará para evitar la exposición excesiva al sol. (2) Solo el camper puede usar el protector solar aprobado por la FDA para uso sin receta. **Iniciales_____:** Si mi hijo no puede aplicar físicamente el protector solar, doy permiso para que el personal del campamento ayude a aplicar el protector solar cuando mi hijo/a lo indique. **Iniciales: _____.**

Por la presente doy permiso al personal médico seleccionado por el director del campamento para ordenar radiografías, exámenes de rutina, tratamiento; para liberar cualquier registro necesario para fines de seguro; y para proporcionar o arreglar el transporte relacionado necesario para mi hijo. En caso de que no pueda contactarme en caso de una emergencia, por la presente autorizo al médico para asegurar y administrar el tratamiento, incluida la hospitalización, para la persona mencionada anteriormente. Este formulario completo se puede fotocopiar si es necesario. Además, el campamento tiene permiso para obtener una copia del registro de salud de mi hijo de los proveedores que tratan a mi hijo y estos proveedores pueden hablar con el personal del programa sobre el estado de salud de mi hijo.

Como padre legal, confirmo que todas las vacunas necessario para que mi hijo va a una escuela en el estado de Nueva York están actualizadas, incluida la vacuna MMR. El mes, día y año de las dos vacunas MMR están documentados en los registros de vacunación de mi hijo.

FIRMA DEL PADRE/TUTOR LEGAL: _____ F**ECHA: _____**

HFH Summer Camps
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HFH Summer Camps Parental Consent & Release Form

For Camp Use Only:

Cabin: _____

Unit: _____

Session: _____

The following form must be sign by a parental/ legal guardian. If for religious reasons you cannot sign this form, contact the central office for a legal waiver, which must be signed for attendance.

Child's Name: _____

Child's Date of Birth: _____

As the Parent/Guardian of the above-named child:

I permit my child to attend HFH Summer Camps and use transportation (e.g. bus or van) supplied by the program.

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.

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.

I permit HFH Summer Camps to call the case manager noted on my child's application if consultation is needed.

I agree that HFH Summer Camps is not responsible for any lost or damage clothing or items my child brings with them to their summer camp session.

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 my child not receiving the vaccine.

The following form pertains to your child's medical information. It must be sign by a parental/ legal guardian. If for religious reasons you cannot sign this form, contact the central office for a legal waiver, which must be signed for attendance.

As the Parent/Guardian of the above-named child, the health history provided 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.

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: _____.**

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 if needed. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

As the Parent/Guardian I attest that all immunizations required for my child to attend school in NY State are up to date including the MMR vaccination. The month, day and year of the two MMR vaccanations are documented on my child's immunization records.

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

HFH Summer Camps
WAKONDA LANOWA

Pick up/Drop-off Authorization Form for the 2020 Camp Season

Please fill out Part 1 if you authorize an adult 18 yrs. or older to pick up/drop off your child at the bus location.
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 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 2019 HFH Summer Camp Session.

Parent Signature: _____ Date: _____

HFH Summer Camps WAKONDA LANOWA

Formulario de autorización para recoger para la temporada de campamento 2020

Por favor complete la Parte 1 si autoriza a un adulto de 18 años. o mayores para recoger / dejar a su hijo/a en las ubicaciones de autobuses. Solo **complete la Parte 2** **si no autoriza** a otra persona a recoger o dejar a su hijo/a.

Parte 1

Yo, _____ (Escriba el nombre del padre / tutor) autorizar los indicados a continuación para recoger y dejar a _____ (Escriba el nombre del Niño/a), en la ubicación de autobús asignada de mi hijo para su sesión de campamento de verano de HFH.

Firma de los padres _____ Fecha_____

Nombre: _____ Relación acerca del Niño: _____

Teléfono: _____

Nombre: _____ Relación acerca del Niño: _____

Teléfono: _____

Nombre: _____ Relación acerca del Niño: _____

Teléfono: _____

Parte 2

☐ **Por favor marque aquí si no autoriza a nadie más que a usted mismo**

Yo, _____ (Escribe el nombre del padre / tutor), No autorice a nadie más para recoger o dejar a mi hijo/a_____ (Escriba el nombre del Niño/a) para su sesión de campamento de Verano de HFH 2019.

Firma de los padres: _____ Fecha: _____

HFH Summer Camps WAKONDA LANOWA

american camp association ACCREDITED

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

MEDICAL FORM PART A

To Parent/ Guardian: Complete pages 1 – 3

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

Parent/Guardian Full Name:_____ Phone:_____

Address: _____ Apt #: _____ City: _____ Zip: _____

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/Child have Medicaid ☐ Yes ☐ No

- **If Yes**, 11-digit Medicaid access no. __ __ __ __ __ __ __ __ __ __ __ Medicaid Sequence No. __ __
- **If No,** Name of Private Insurance Co.: _____ Group or Policy#: _____

  Name of Insurance Policy Holder:_____ Carrier Phone Number:_____

ROUTINE MEDICATION

Please list **ALL** medications (including over-the-counter/ non-prescription drugs) taken routinely. If more than 3 please use back of sheet.

☐ This child takes **NO** medication on a routine basis
☐ This child 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:	

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: Campers 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

My child is allergic to:	**Name** (ex: peanuts)	**Reaction** (ex: hives)	**Management** (ex: must be given medication)
Medication			
Food			
Other (Ex: Dust, dogs, hayfever)			

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

For Camp Use Only: Campers Name: _____ 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.

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 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. Children are not routinely recommended to receive MenACWY vaccine prior to the recommended ages, unless they have certain underlying medical conditions which increase their risk of disease. The meningococcal B (MenB) vaccine protects against a fifth strain of meningococcal bacteria which causes 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.

I encourage you to carefully review the attached Meningococcal Disease Fact Sheet. It is also available on the New York State Department of Health website at: http://www.health.ny.gov/publications/2168.pdf.

Information about the availability and cost of meningococcal vaccine can be obtained from your healthcare provider or your local health department. HFH Summer Camp does not provide Meningococcal Immunization Services.

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

- Receipt and review of meningococcal disease and vaccine information;
  AND EITHER
- Certification that the camper has been immunized against meningococcal meningitis within the past 10 years; OR
- An understanding of meningococcal disease risks and benefits of vaccination at the recommended ages and the decision not to obtain immunization against meningococcal meningitis at this time.

Please complete the enclosed Meningococcal Meningitis Vaccination Response Form and return it to HFH Summer Camps. To learn more about meningococcal meningitis and the vaccine, please feel free to 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 Camp

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.

The Centers for Disease Control and Prevention recommends two doses of MenACWY vaccine (Brand names: Menactra, Menveo) for all healthy adolescents 11 through 18 years of age: the first dose is given at 11 or 12 years of age, with a booster dose at 16 years of age. Children and adolescents with certain medical conditions may need to begin the MenACWY series at a younger age and/or receive additional doses. Consult with your child's healthcare provider regarding any medical conditions they may have.

If the first dose 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 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.

Check one box and sign below.

☐ I have received and reviewed the information regarding meningococcal meningitis. My child has received meningococcal immunization (Menactra or Menveo) within the past 10 years.

Date received:_____

OR

I have received and reviewed the information regarding meningococcal meningitis. I understand the risks of meningococcal meningitis and the benefits of immunization at the recommended ages.

☐ I have decided that **my child**, who is **younger than 11 years of age**, will **not** obtain immunization against meningococcal disease at this time; or

☐ I have decided that **my child**, who is **11 years of age or older**, will **not** obtain immunization against meningococcal disease at this time.

Signed: _____ Date: _____
(Parent / Guardian)

Camper's Name: _____ Date of Birth: _____

Mailing Address: _____

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

HFH Summer Camps WAKONDA LANOWA

MUST BE COMPLETED, SIGNED AND STAMPED BY DOCTOR

MEDICAL FORM PART B

A doctor MUST complete Medical Form Part B. The physical examination must have been conducted on or after June 1, 2019

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: _____

_____

For Camp Use Only:

Campers Name:_____

Cabin:_____

Unit:_____

Session:_____

MUST BE COMPLETED, SIGNED AND STAMPED BY DOCTOR

IMMUNIZATIONS

Provide the month and year for each immunization. Starred (*) immunizations must include Month, Day and Year. Copies of immunization forms from health-care providers or state or local government are acceptable. Please note all children must have all immunizations required for the child to attend school in NY State in order to attend camp and must have received two doses of the MMR vaccinations in order to attend camp.

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) (Month/Day/Year)							
Mumps, measles, rubella* (MMR) (Month/Day/Year)							
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:

Campers Name:_____

Cabin:_____

Unit:_____

Session:_____

HFH Summer Camps WAKONDA LANOWA

ASTHMA ACTION PLAN

If applicable, must be completed and Signed by Doctor and Parent/Guardian.

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

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:
Campers Name: _____
Cabin: _____
Unit: _____
Session: _____

HFH Summer Camps
WAKONDA LANOWA

Child's Name:_____

Date of Birth: _____

Current Age: _____

Gender: ☐ M ☐ F

For Camp Use Only:

Cabin:_____

Unit:_____

Session:_____

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 Summer Camp staff should be aware of to ensure your child has a fun and safe experience:

_____

INCOME ELIGIBILITY FORM
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:_____