

SUMMER CAMP

Welcome to Faith Lutheran's 2023 Summer Camp!

Our summer camp consists of both indoor and outdoor activities.

Our indoor activities include, but are not limited to, arts and crafts, free play (dramatic play, building, games, books, painting, etc.), parachute play, rainy day music and dance.

Our outdoor activities (weather permitting) include, but are not limited to, bike riding, bubbles, sidewalk chalk, sprinkler and water activities, playground play and group games.

We ask that if your child is interested in the bike riding activities, that you bring your child's own bike and helmet. A properly fitted helmet is a necessity for bike riding safety. We do have a limited number of school scooters/cars/tricycles, but a helmet from home will still be needed.

Also, with weather permitting, a bathing suit and towel is needed to enjoy our water activities. Your child may wear the bathing suit to camp under their clothing (please bring underclothes in bag). They change into dry clothes before lunch.

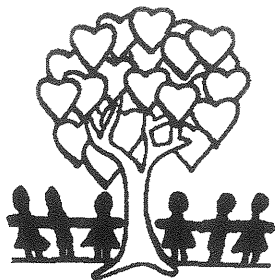
Please remember to apply sunscreen to your child at home before coming to camp. Camp staff cannot apply sunscreen due to possible allergies or rash.

Please remember to bring a lunch labeled with your child's name. Please pack an ice pack. We also have a microwave for any items that may need to be heated such as soup, nuggets, macaroni and cheese, etc.

If you have any questions, please feel free to call 732 793-6972.

We look forward to a great fun-filled summer with your child!

Nora Collins, Director
Faith Lutheran's Summer Staff



Faith Lutheran Summer Camp
1801 Grand Central Avenue
Lavallette, NJ 08735
(732) 793-6972

Child's Name _____ DOB _____

Summer Address _____

Best Number(s) to Contact You _____

Winter Address _____

Mother's Name _____ Mother's Email _____

Father's Name _____ Father's Email _____

In case of Emergency, please contact the following:

(1) _____
(Name) (Phone)

(2) _____
(Name) (Phone)

If none of the above can be reached, I hereby authorize the Nursery School Staff to take appropriate emergency action for the safety of my child. _____

(Initial)

AUTHORIZED STUDENT PICK-UP LIST

(1) _____
(Name) (Relationship) (Phone)

(2) _____
(Name) (Relationship) (Phone)

(3) _____
(Name) (Relationship) (Phone)

Parent's Signature _____ Date _____

My child is up to date on required immunizations required by the Ocean County Health Department. _____ (Initial)

My child is in good health and may participate in the activities of the Summer Camp program. _____ (Initial)

Please attach Universal Child Health Record form and immunization records from doctor.

ALLERGIES:

DESCRIBE YOUR CHILD'S MEDICAL CONDITION: _____

Parent's Signature: _____ Date: _____

Fees

3 ½ Hour Session

9:00am – 12:30pm

\$35.00 Per Session*

10% discount on 2nd child

(Please fill out separate application for each child)

*****Lunch is from 11:40am - 12:15pm*****

Non-refundable \$35.00 Registration Fee Received: _____ Date: _____

Please check the following chart as appropriate for your child.

	Tuesday	Wednesday	Thursday
Week 1 – July 5 - 6	Closed for July 4th	_____	_____
Week 2 – July 11 - 13	_____	_____	_____
Week 3 – July 18 - 20	_____	_____	_____
Week 4 – July 25 - 27	_____	_____	_____
Week 5 – Aug. 1 - 3	_____	_____	_____
Week 6 – Aug. 8 -10	_____	_____	_____

Please multiply the number of days with the \$35 daily fee. Please add in the \$35 registration fee.

Number of Days: _____
Daily Fee: _____ X \$35.00
Less 10% discount 2nd child: _____
Please fill out separate application for 2nd child
Registration Fee (per family): _____ + \$35.00
Total: _____ = _____

Please make checks payable to ***“Faith Lutheran”***

Please mail to:

Faith Lutheran Summer Camp
Attn: Nora Collins
1801 Grand Central Avenue
Lavallette, NJ 08735

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)					
Child's Name (Last)		(First)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier			
Parent/Guardian Name		Home Telephone Number () -		Work Telephone/Cell Phone Number () -	
Parent/Guardian Name		Home Telephone Number () -		Work Telephone/Cell Phone Number () -	
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.					
Signature/Date				This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination:			Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Abnormalities Noted:			Weight (must be taken within 30 days for WIC)		
			Height (must be taken within 30 days for WIC)		
			Head Circumference (if <2 Years)		
			Blood Pressure (if >3 Years)		
IMMUNIZATIONS			<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____		
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
PREVENTIVE HEALTH SCREENINGS					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.					
Name of Health Care Provider (Print)			Health Care Provider Stamp:		
Signature/Date					

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)

- **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
- **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
- **Head Circumference** - Only enter if the child is less than 2 years.
- **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.

- "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

- a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.
- b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.

c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

d. **Special Equipment** - Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

g. **Behavioral/Mental Health issues** - Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.

- For lead screening state if the blood sample was capillary or venous and the value of the test performed.
- For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
- Scoliosis screenings are done biennially in the public schools beginning at age 10.

This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)

- Print the health care provider's name.
- Stamp with health care site's name, address and phone number.