SUMMER CAMP

Welcome to Faith Lutheran's 2024 Summer Camp! Our summer camp registration starts at 2 ½ (with successful toilet training) up to age 7.

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: _____

_____

IS YOUR CHILD FULLY TOILET TRAINED? _____

Parent's Signature: _____ Date: _____

Fees

3 ½ Hour Session	9:00am – 12:30pm	$40.00 Per Session*

10% discount on 2nd child

(Please fill out separate application for each child)
FULL payment is due at time of registration.

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

Please check the following chart as appropriate for your child.

	Tuesday	Wednesday	Thursday
Week 1 – July 9-11	_____	_____	_____
Week 2 – July 16-18	_____	_____	_____
Week 3 – July 23-25	_____	_____	_____
Week 4 – July 30- Aug.1	_____	_____	_____
Week 5 – Aug. 6- 8	_____	_____	_____
Week 6 – Aug. 13-15	_____	_____	_____

Please multiply the number of days with the $40 daily fee. Please add in the $35 registration fee.

Number of Days: _____

Daily Fee: X $40.00

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"***

FULL payment is due at time of registration.

Please mail to:

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

APPENDIX H

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 ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐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. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐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	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ 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: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***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	