Campus Day Camp

2901 Campus Rd. Brooklyn, N.Y. 11210
(718) 421-7575

Registration Checklist:

- ☐ Completed and signed registration form.
- ☐ If before May 31, 2019 a deposit of $500. (Full balance due on 5/31/19)
- ☐ If after June 1, 2019 full camp tuition.
- ☐ NYC DOH Medical Form filled out by a physician that includes all immunizations (PPD, MMR). This is based on a checkup done within one calendar year. A current form must always be on file.
- ☐ A completed Lunch Form.
- ☐ A fully completed and signed trip itinerary.

All items must be complete and submitted **BEFORE** your child starts.

CAMPUS DAY CAMP 2019

2901 Campus Rd. Brooklyn, N.Y. 11210 718-421-7575

Today's Date: _____

1. Child's Information

Name: _____ Sex: M ☐ F ☐

School: _____ Grade Entering: _____

Known Allergies: _____Medical Conditions/Restrictions: _____

Birth Date: _____ Age (by June 27): _____ Siblings/Age: _____

*Special Needs: Yes ☐ No☐ If Yes Describe: _____

2. Parent/Guardian Information

Guardian: (Relationship) _____

Name: _____

Occupation: _____

Address: _____

Apt: _____Zip/City: _____

Cell: _____

Home Phone: _____

Work Phone: _____

E-Mail: _____

Guardian: (Relationship) _____

Name: _____

Occupation: _____

Address: _____

Apt: _____Zip/City: _____

Cell: _____

Home Phone: _____

Work Phone: _____

E-Mail: _____

3. Child Pick-up and Emergency Contact Information:

Please list persons with phone numbers whom you give permission to pick-up your child from the program.
Please note that we will not release children to anyone not on this list without prior authorization.
Children will not be released to anyone under the age of 16.

In the event of an emergency, these people will be contacted if a parent/guardian is unavailable.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

CONTINUE ON OTHER SIDE

4. Camp Fees

Tuition

Grade Entering	Full Summer 9:00am- 4:15pm	One Session 9:00am- 4:15pm
Adventurers K-2nd Grade	$2250.00	$2050.00
Discoverers 3rd-4th Grade	$2350.00	$2150.00
Explorers 5th-10th Grade	$2450.00	$2250.00

Additions

Options	Full Summer	One Session
Bus One Way	$250	$125
Bus Both Ways	$500	$250
Early Drop 7:30 am	$300	$150
Late Stay 6:00 pm	$300	$150
Late Stay 7:00 pm	$350	$175

Deposit of $500.00 must be paid at time of registration.
Deposit will be applied to camp fee.
Camp must be paid for in full by no later than May 31, 2019.
Full summer is June 27-August 14. Single session is either June 27-July 19 or July 20-August 14

FOR OFFICE USE ONLY

Full Summer ☐ First Session ☐ Second Session ☐ Bus A.M. ☐ Bus P.M. ☐ Early ☐ 6pm ☐ 7pm ☐

Total Fee $_____ Deposit Paid: $_____ Date Paid: _____ Balance: $_____

Payment Method: _____ Notes: _____

5. Parent/Guardian Consent

In case of an emergency injury or illness, I authorize the program to call the paramedics. As legal guardian of the above listed student, a minor, I authorize the program representative designee to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered upon the advice of any licensed physician and/or dentist.

There will be no refund or pro-rating for absenteeism. It is our policy to charge $5.00 per quarter hour past closing time, which is 4:15 or 6:00 or 7:00 PM. If child is pulled out from program before end of summer no refund will be given.

Rules and regulations must be adhered to at all times.
Campus ASP Inc. reserves the right to suspend or expel a child from the program for disruptive or dangerous behavior.

Campus ASP Inc. and its employees are not responsible for personal items.

***We do not have a special needs program. Children may be accepted if they are able to be included within the group and do not require one on one or any other additional services. We require a trial before admission of any child with special needs.**

I give consent for Campus ASP Inc. to pick up my child and attend trips using our full size school buses, mini buses, passenger vans, minivans/cars or by walking. ☐ **Yes**

I give my consent for my child to attend Campus ASP Inc. and participate in its activities and trips. ☐ **Yes**

I understand that my child will receive lunch and snack daily. ☐ **Yes**

Campus ASP Inc. may at times use your child's image on promotional items, both in print and online.

I have read and understand the above.

Parent/Legal Guardian Signature_____ **Date**_____

CONTINUE ON OTHER SIDE

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* __ __ / __ __ / __ __ __ __

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough | State | Zip Code | School/Center/Camp Name | District Number __ __ __ | **Phone Numbers** *Home* _____ *Cell* _____ *Work* _____

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** Last Name | First Name | ☐ **Foster Parent**

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

_____

_____

Dietary Restrictions

☐ None ☐ Yes *(list below)*

_____

PHYSICAL EXAMINATION

Height _____ **cm** (__ __ %ile)

Weight _____ **kg** (__ __ %ile)

BMI _____ **kg/m²** (__ __ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (__ __ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

	NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl
☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development
☐	☐	Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language
☐	☐	Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	Behavioral

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__/__/__	_____ µg/dL
	__/__/__	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__/__/__	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	_____ g/dL _____ %

	Date Done	*Results*
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration _____mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* ___ / ___ *Left* ___ / ___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus	__/__/__	__/__/__	__/__/__	__/__/__
DTP/DTaP/DT	__/__/__	__/__/__	__/__/__	__/__/__
	__/__/__	__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__	__/__/__

Influenza	__/__/__	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__		
Td	__/__/__	__/__/__	__/__/__	__/__/__
Tdap __/__/__	Hep A	__/__/__	__/__/__	
Meningococcal	__/__/__	__/__/__		
HPV	__/__/__	__/__/__	__/__/__	
Other, *specify:* _____	__/__/__	_____	__/__/__	

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __/__/__

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

_____ __ __ __ __

_____ __ __ __ __

_____ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

DOHMH ONLY **PROVIDER I.D.**

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: __/__/__ **I.D. NUMBER**

REVIEWER:

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian

Campus After School Program

2901 Campus Rd. Brooklyn, N.Y. 11210
(718) 421-7575

CHECKING/SAVINGS WRITTEN AUTHORIZATION FORM

I (we) hereby authorize Campus ASP Inc. to initiate entries to my (our) checking/savings accounts at the financial institution listed below (THE FINANCIAL INSTITUTION), and, if necessary, initiate adjustments for any transactions credited/debited in error. A $30 charge will occur if your payment is denied by your bank.

Child's Name:_____

_____
(Name of Financial Institution)

_____
(Address of Financial Institution Branch, City, State, & Zip)

Please Circle Type of Account: Checking Savings

_____ _____
(Routing Number) (Account Number)

Amount of $_____

Account will be kept on file for future charges.

_____
(Consumer Name PLEASE PRINT)

_____
(Consumer Address PLEASE PRINT)

_____ _____
(Signature) (Date)

If you should need to notify us of your intent to cancel and/or revoke this authorization you must contact us 1 week prior to the questioned debit being initiated. Please call 718-421-7575 or email at info@campusasp.com Monday-Friday from 10:00am to 6:00pm.

Campus After School Program

2901 Campus Rd. Brooklyn, N.Y. 11210
(718) 421-7575

Credit Card Payment Authorization Form

Sign and complete this form to authorize Campus ASP Inc. to make charges to your credit card listed below.

By signing this form you give us permission to charge your account for the amount indicated.

Please complete the information below:

Child's Name:_____

I _____ authorize Campus ASP Inc. to automatically charge my credit card
(full name)

account indicated below for _____ and to keep this account on file for future charges.
(amount)

Billing Address _____

City, State, _____

Zip Code, _____

Account Type: ☐Visa ☐MasterCard ☐Amex

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC or 4 on front of Amex) _____

SIGNATURE _____ DATE _____

I authorize the Campus ASP Inc. to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for the dates indicated. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

CACFP
Child and Adult Care Food Program
New York State Department of Health

INCOME ELIGIBILITY FORM
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME: _____

Print the name of the child(ren) enrolled in this child care center:

1. _____ 2. _____ 3. _____

DIRECTIONS:

Complete SECTION A if anyone in your household:

1. Receives Food Stamps
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. If any of the children enrolled in this child care center are foster children

Complete SECTION B if no one in your household receives Food Stamps, TANF, FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION A

Food Stamp Case Number _____

TANF Number _____

FDPIR Number _____

Names of Foster Children _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature: _____

Date: _____

FOR SPONSOR USE ONLY

Sponsor Agreement Number _____

Total Household Members _____
(including foster children, if applicable)

Total Income $_____

Free _____ Reduced _____ Paid _____

Date Determined _____ / _____ / _____

Signature of Center Staff_____

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

Name of Household Members	Monthly Gross Income
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature: _____

Print Name: _____

SS# XXX-XX-__ __ __ __ Date: _____