בס"ד

Method of Payment:

Please choose one of the following payment Method and include all information.
Payment must be made in full before camp. Thank you.

☐ **Check**

Note: The payment must be made in full. Checks may be postdated to June 24th. Checks should be made out to United Lubavitcher Yeshiva- write "Machane Heights" in memo.

☐ **Cash**

☐ **Credit Card**

Name of child	
Card Type	
Name on Card	
Card #	
Expiration Date	
Security Code	
Address	
Phone #	
Total amount owed	
Dates to charge the card	☐ ASAP ☐ June 24th *The $40 registration fee will be charged ASAP.

INFORMED CONSENT AND HOLD HARMLESS/RELEASE AGREEMENT

I understand that participation in camp activities involves a certain degree of risk and can be physically, mentally, and emotionally demanding. I also understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

I have carefully considered the risk involved and give consent for myself and/or my child to participate in these activities. I approve the sharing of the information on this form with Machane Heights Day Camp staff and professionals who need to know of medical situations that might require special consideration for the safe conducting of camp activities.

I release Machane Heights Day Camp, JCC of Greater Coney Island, and ULY Crown St., the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation.

☐ Without restrictions.

☐ With special considerations or restrictions (list) _____

_____

TALENT RELEASE AGREEMENT

I hereby assign and grant to Machane Heights Day Camp the right and permission to use and publish the photographs/ film/videotapes/electronic representations and/or sound recordings made of me or my child at all camping activities. I hereby release Machane Heights Day Camp, the local council, the activity coordinators, and all employees, volunteers, related parties, br other organizations associated with the activity from any and all liability from such use and publication.

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.

The participant has permission to engage in all camp activities including, but not limited to: swimming, sports, bicycling, barbeques, any and all excursions/field trips, and shabbatons. high-adventure activities described, except as specifically noted by me or the health-care provider.

Participant's name _____

Participant's signature _____ Date _____

Parent/guardian's signature _____ Date _____

(if participant is under the age of 18)

Second parent/guardian signature _____ Date _____

PERMISSION SLIP FOR ALL FIELD TRIPS/EXCURSIONS

Child's Name_____

I give permission for my child to attend all field trips and excursions with **Machane Heights Day Camp** during the summer season 2018.

I understand that these trips may involve bicycling to and from these several locations and/or use of public transportation and/or use of buses.

In the event of emergency, use the emergency contact information provided on the registration form. Generally, I can be reached at (____)_____ during the day.

Parent/guardian's signature _____ **Date** _____

CHILD & ADOLESCENT HEALTH EXAMINATION FORM
NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS) ☐☐☐☐☐☐☐☐☐

TO BE COMPLETED BY THE 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 ______

Health insurance (including Medicaid)? ☐ Yes ☐ No	☐ Parent/Guardian ☐ Foster Parent	Last Name	First Name	Email	Cell ______ Work ______

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ______ weeks gestation

☐ Complicated by ____________________

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ____________________

☐ Foods *(list)* ____________________

☐ Other *(list)* ____________________

Attach MAF if in-school medications needed

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

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

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis	☐ Seizure disorder	**Medications** ***(attach MAF if in-school medication needed)***
☐ Behavioral/mental health disorder	☐ Speech, hearing, or visual impairment	☐ None ☐ Yes *(list below)*
☐ Congenital or acquired heart disorder	☐ Tuberculosis *(latent infection or disease)*	____________
☐ Developmental/learning problem	☐ Hospitalization	____________
☐ Diabetes ***(attach MAF)***	☐ Surgery	____________
☐ Orthopedic injury/disability	☐ Other (specify) ________	____________
Explain all checked items above.	☐ ***Addendum attached.***	

PHYSICAL EXAM **Date of Exam:** ___ /___ /___

Height	______ **cm**	(___ ___ %ile)
Weight	______ **kg**	(___ ___ %ile)
BMI	______ **kg/m²**	(___ ___ %ile)
Head Circumference *(age ≤2 yrs)*	______ **cm**	(___ ___ %ile)
Blood Pressure *(age ≥3 yrs)*	______ / ______	

General Appearance:

☐ Physical Exam WNL

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

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ____/____/____

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving	☐ Adaptive/Self-Help
☐ Communication/Language	☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social	☐ Other Area of Concern: ______

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< **1 year** ☐ Breastfed ☐ Formula ☐ Both

≥ **1 year** ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

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
—— Child Care Only ——		
Hemoglobin or Hematocrit	____ /____ /____	______ g/dL ______ %

Hearing	*Date Done*	*Results*
< 4 years: gross hearing	____/____/____	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	____/____/____	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	____/____/____	☐*Nl* ☐*Abnl* ☐*Referred*

Vision	*Date Done*	*Results*
<3 years: Vision appears:	____/____/____	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	____/____/____	Right ____/____ Left ____/____ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental	
Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number ☐☐☐☐☐☐☐☐☐☐

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	Tdap	__/__/__	__/__/__		
Td	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__		MMR	__/__/__	__/__/__	__/__/__	
Polio	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__		Varicella	__/__/__	__/__/__	__/__/__	
Hep B	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__		Mening ACWY	__/__/__	__/__/__	__/__/__	
Hib	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__		Hep A	__/__/__	__/__/__	__/__/__	
PCV	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__		Rotavirus	__/__/__	__/__/__	__/__/__	
Influenza	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__		Mening B	__/__/__	__/__/__	__/__/__	
HPV	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__		Other ______	__/__/__	______	__/__/__	

IgG Titers	Date
Hepatitis B	__/__/__
Measles	__/__/__
Mumps	__/__/__
Rubella	__/__/__
Varicella	__/__/__
Polio 1	__/__/__
Polio 2	__/__/__
Polio 3	__/__/__

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

____________________ ______

____________________ ______

____________________ ______

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* ____________________

Follow-up Needed ☐ No ☐ Yes, for ____________ Appt. date: _ _ / _ _ / _ _

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other ____________________

Health Care Practitioner Signature	Date Form Completed ____ /____ /____
Health Care Practitioner Name and Degree *(print)*	Practitioner License No. and State
Facility Name	National Provider Identifier (NPI)

Address	City	State	Zip

Telephone	Fax	Email

DOHMH ONLY — **PRACTITIONER I.D.** ☐☐☐☐☐☐

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

Comments:

Date Reviewed: ____ / ____ / ____ **I.D. NUMBER** ☐☐☐☐☐☐

REVIEWER:

FORM ID# ☐☐☐☐☐☐☐☐☐☐