Shin Kwang Christian Summer Camp Registration Form [여름캠프 등록원서]

Director: Esther Lee
33-55 Bell Blvd. Bayside NY 11361
(718) 357-3355 (church office), (718) 450-2082 (director)
Email: nyskcm@gmail.com

※ Must fill out one application per child (두명 이상의 자녀분이 계실 경우 각자 등록 신청서를 따로 작성하셔야 합니다)

Name [이름]	[한글]		[English]	
DOB (생년월일): / / (mm/dd/yy)		( ) **Grade in September 2024** 금년 9 월에 올라갈 학년		Sex (성별) : ☐남 M ☐여 F
Address [집주소]				
Parent/Guardian Information [부모성명]	**Mother/Guardian** (어머니/보호자):		**Father/Guardian** (아버지/보호자):	
	Home # (집)		Home # (집)	
	Work # (직장):		Work # (직장):	
	Cell # (핸드폰):		Cell # (핸드폰):	
	E-mail:		E-mail:	

Emergency Contact [긴급 연락처]	Name (성명)	Contact # (전화번호):	Relationship (관계):
	Name (성명)	Contact # (전화번호):	Relationship (관계):
Siblings attending this summer school [여름학교 출석 형제]	Name (성명)	Grade (학년):	DOB (생년월일):
	Name (성명)	Grade (학년):	DOB (생년월일):
Church Attending [출석교회]	1) ☐ Church (교회):	2) ☐ Catholic (카톨릭):	3) ☐ Not attending any church (교회 안 다님)
Registration [등록]	T-Shirt Size Check One: ☐ Small (6-8) ☐ Medium (10-12) ☐ Large (14-16) ☐ Other: _____		
	Please make checks payable to: Shin Kwang Church of New York		
	****There are no refunds on tuition****		

PARENTAL/GUARDIAN RELEASE AND PERMISSION

I,_____, as the legal guardian of above named child, release, absolve and hold harmless Shin Kwang Church, its teachers, volunteers, staff, and directors in case of any incident that may occur in relation to Shin Kwang Christian Summer Camp. I give my child permission to attend Shin Kwang Church Summer Camp and participate in all activities and will comply with the mask mandates. I hereby consent to the participation in interviews, the use of quotes, and the taking of photographs, movies or videos of the student registered above. I also grant the right to edit, use, and reuse said products for non-profit purposes including use in print, on the internet, and all other forms of media. I understand, according to Shin Kwang Christian Summer Camp refund policy, that there are absolutely **NO REFUNDS** on camp registration, tuition and/or fees.

Liabilities Release Confirmation: The staff of this summer camp will do their best to assure all appropriate and reasonable safety measures with respect to your child's attendance, travel, and other activities (such as day trips) associated with the summer camp. However, the School will not assume any liability incurred as a result of any attendance, travel, and other activities related with the School. I read this condition and I waive my rights to take any legal action against this camp and/or its staff.

I have read this release and permission and approve of its terms.

Parent/Guardian Signature (보호자 서명): _____ Date (날짜): _____

For Office Use:			
Date Received	**Payment**	**Waiver Form**	**Medical Record**
/ / 2024	**/ / 2024**	**/ / 2024**	**/ / 2024**

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×ALL STUDENTS MUST HAVE RECENT NYC HEALTH FORM COMPLETED BY PHYSICIAN/ DOCTOR IN ADDITION TO THIS FORM*

☐ *SHIN KWANG CHRISTIAN CHURCH SUMMER CAMP 20___*
☐ *SUPPLEMENTAL MEDICAL FORM*

Child's Name: _____ Grade: _____

Date of Birth : _____ Age: _____

Phone: _____

I, _____ (print guardian's name), give permission to Shin Kwang Church of New York Christian Summer Camp to administer the following first aid items in case of emergencies and daily temperature checks before entering the camp to _____(print child's name).

x _____ _____
Guardian's Signature Date

☐ **Please <u>check</u> all that may be administered to your child:**
귀하의 자녀에게 투여될 수 있는 사항을 모두 표시해 주십시오:

☐ Digital Thermometer | 디지털 온도계
☐ Alcohol Swabs | 알코올 면봉
☐ Anti-Itch Ointment | 가려움증 방지 연고
☐ Gauze Pads | 거즈 패드
☐ Antibiotic Ointment | 항생제 연고
☐ Skin Lotion | 스킨로션
☐ Hydrogen Peroxide | 과산화수소
☐ Pepto-Bismol | 펩토비스몰
☐ Cough Syrup | 기침시럽
☐ Bandages | 붕대, 반창고
☐ Ice Bag | 얼음주머니
☐ Tylenol | 타이레놀, 해열제
☐ Ibuprofen | 아이브프로펜

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