2020 Honeydew Summer Camp Registration Form

THIS FORM MUST BE COMPLETED BY PARENT/ GUARDIAN AND SUBMITTED WITH PAYMENT AND OTHER REQUIRED DOCUMENTS BEFORE REGISTRATION WILL BE ACCEPTED.

THE PERSON REGISTERING THIS CAMPER IS RESPONSIBLE FOR MAKING ALL PAYMENTS

Please use one form per child. Copies may be made of this form.

PRINT NEATLY WTH BLUE OR BLACK INK. FILL IN **ALL** INFORMATION

Camp runs from 9am-4pm, with additional hours available (see below)

CAMPERS GENERAL INFORMATION (where camper resides)

Is this the camper's first summer at Honeydew Drop ? ☐ **Yes** ☐ **No** ☐ **Male** ☐ **Female**

Camper Birth Date___/___/____ Camper Age:___

Last Name_____ First Name_____ Middle_____

Parent/GuardiansFull Name(s)_____

Mailing address_____

City_____ State_____ Zip_____

Name of person registering this camper (If other than Parent/Guardian)

Relationship to Camper _____

Registrant's Phone number _____Email _____

Camper lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other_____

Please place a check next to the number and email that is best to use as a first contact.

Parent #1 Relationship: _____ Parent #2 Relationship: _____

☐ Parent #1 Work Telephone_____ ☐ Parent #2 Work Telephone_____

☐ Parent #1 Cell Phone_____ ☐ Parent #2 Cell Phone_____

☐ Parent #1 Email_____ ☐ Parent #2 Email_____

How did you learn about Honeydew Summer Camp? (ie: referral, advertisement, church)?_____

_____

EMERGENCY CONTACT FORM REQUIRED* **LIST INDIVIDUALS OTHER THAN PARENT/GUARDIAN**

Emergency Contact #1_____ Telephone_____ ☐Home☐Cell

Relationship to Camper_____ PASSCODE: _____ ☐Work

Emergency Contact #2_____ Telephone_____ ☐Home☐Cell

Relationship to Camper_____ PASSCODE: _____ ☐Work

***If camper is residing with a friend or relative other than parent/guardian during the week they are attending camp, please list that individual as Emergency Contact #1.**

Please note, for the safety of the children we DO NOT release your child to anyone who is not listed as an emergency contact or under the age of 18 years old.

Send Registration, MEDICAL and CONSENT FORMS with **FULL PAYMENT** to:
FABIOLA SANTOS-GAERLAN, 277 14TH STREET BROOKLYN, NY 11215 / (877-61-HONEY)
Payment Options: Money Order, Cash, or Personal Checks, payable to the **FABIOLA SANTOS-GAERLAN**

Camper Name _____

GENERAL REGISTRATION INFORMATION

REGISTER EARLY and SAVE 10%! Submit registration, payment and all supporting documents by regular mail or email before April 15, 2020 . This early bird does not include soccer class and registration fee.

Please include payment and all required forms with registration or processing will be delayed. Remember to sign the **CONSENT FORM** and include your **MEDICAL FORM COMPLETED BY PHYSICIAN** copies and **IMMUNIZATION RECORD**.

Please note: all immunizations are mandatory for all campers.

IN CAMP – *WEEKLY FEE $380* / Optional Extended Hours for Additional Fee (see below)

Please check all week/options in which your child wishes to participate. You will be notified of any availability issues.

Payment for all weeks is due at time of registration. You are liable for each week you sign-up for.

CHECK FOR WEEKS	Weeks	Dates	Day-by-Day (circle needs) (see rate below) only check day-2-day, if your not signing up for week-by-week	Additional Hours (circle needs)	WHICH DAYS DO YOU NEED ADDITIONAL HOURS?	CHECK FOR WEEKS	Add-ons (see rate below)
☐	1	**June 29- July3** (June 3, we are closed)	MON TUE WED THUR FRI	☐8-9am ☐4-6PM		☐	Soccer Class
☐	2	**July 6 – July 10**	MON TUE WED THUR FRI	☐8-9am ☐4-6PM		☐	Soccer Class
☐	3	**July 13- July 17**	MON TUE WED THUR FRI	☐8-9am ☐4-6PM		☐	Soccer Class
☐	4	**July 20 – July 24**	MON TUE WED THUR FRI	☐8-9am ☐4-6PM		☐	Soccer Class
☐	5	**July 27- July 31**	MON TUE WED THUR FRI	☐8-9am ☐4-6PM		☐	Soccer Class
☐	6	**August 3 – August 7**	MON TUE WED THUR FRI	☐8-9am ☐4-6PM		☐	Soccer Class
	7	**August 10 – August 14**	***CLOSED FOR PROFESSIONAL DEVELOPMENT***		***CLOSED FOR PROFESSIONAL DEVELOPMENT***		
☐	8	**August 17 – August 21**	MON TUE WED THUR FRI	☐8-9am ☐4-6PM		☐	Soccer Class
☐	9	**August 24 – August 28**	MON TUE WED THUR FRI	☐8-9am ☐4-6PM		☐	Soccer Class

am OR pm (Extended day): $60/week

PER DAY RATE: 9-4PM= $90 / 8-6=$100

am AND pm(Extended Day): $100/week

Soccer Class: $10/per session

IN CAMP FEES (see below fees)

1. $100 non refundable registration fee (you will receive 2 Honeydew T-shirt & 1 Draw string bag).
2. $100 non refundable deposit for each week, your child will attend.

TOTAL ENCLOSED: $_____Check must accompany registration form.

Deposits for weeks will be applied when your child/children attend their first day at camp.

Late Pick up fee: $1/min after 4:15PM **Sibling discount:** 10% off second child tuition.

REFUND POLICY **for early bird only**

If your child cannot attend camp for a period of time paid, you may submit a refund request along with the documentation/reason for not attending the camp to the Administrator (enrollement@honeydewdrop.com) at least 2 WEEKS before hand. Request will be granted under the discretion of Honeydew Drop Child Care Inc. Administrators.

OFFICE USE ONLY

Total # of weeks registered: _____

Total Discount: _____

Total Cost of Camp: $_____

Date check given/ Check #:_____/_____

Please check below the campers T-shirt size.

(You will receive 2 HD T-shirts & 1 draw string bag)

☐ S(3-4T) ☐ M(4-5T) ☐L(6-7T)

Camper Name _____

PHASEIN FORMS

FORMS ATTACHED: PERMISSION FORMS
PARENT / HONEYDEW RESPONSIBILITES
MEDICAL FORM (to be filled out & stamped by an official Pediatrician)

HONEYDEW DROP PERMISSION FORMS

I, _____, hereby give my consent for my child, _____, to go on supervised field trips and other curriculum activities outside of Honeydew.

_____
Signature of Parent

_____
Date

I, _____, allow the teachers at Honeydew to administer topical sun block to my child, _____ whenever needed. This sun block will only be applied to the areas of his/her body that will be exposed to the sun. We provide our own sun block lotion and insect repellant that they apply.

_____
Signature of Parent

_____
Date

I, _____, understand that my child, _____, while under the care of Honeydew, will be napping on a mat in the play area of the daycare. He/she will be supervised. If my child is an infant, I also understand that my child will be placed on their back to sleep.

_____
Signature of Parent

_____
Date

I/We, _____, hereby authorize:

_____ _____
Name Phone #

_____ _____
Name Phone #

to escort our child,_____ from Honeydew Drop.

I understand that any person unfamiliar to Honeydew staff will be required to show proof of ID and will be asked the **CODE WORD** that the parents informed us of ahead of time. Under NO circumstances will the child be released to anyone other than those listed above without written permission from the parent.

_____ _____
Signature of Parent Date

I, _____ hereby grant permission to Honeydew to include me in the private Facebook account of the Honeydew site that my child,_____ attends. Only current families enrolled can access this private Facebook account.

_____
Signature of Parent

I, _____ hereby grant permission to Honeydew to feature my child in photos on our website and other limited marketing tools.

_____ _____
Signature of Parent Date

-e read the parent handbook and agree to abide by its policies. Failure to do so will jeopardize our enrollment at Honeydew. We also commit to reading the parent memos, the bulletin boards at our Honeydew site and the Honeydew website private parent portal for information regarding our enrollment and the activities of the children at Honeydew.

* We received 2 Tshirts and a bag ** _____ initial

CHILD'S NAME: _____

PARENT'S NAME: _____

SIGNATURE: _____

DATE: _____

PARENT/HONEYDEW RESPONSIBILITIES SUMMER CAMP

HONEYDEW RESPONSIBILITIES

Honeydew will provide

- Safe, healthy and loving care of the children.
- All meals which include Breakfast, Hot Lunch, and multiple snacks
- Most paper goods such as baby wipes, paper towels, tissues
- Regular communication through: Daily Activities board posted at Honeydew entrance. Private Facebook, Newsletters, Monthly memos from Exec Director, small chats with teachers and longer phone calls or appointments when necessary.
- Parent Orientation to cover Honeydew philosophy, policies and procedures

PARENT RESPONSIBILITIES

Parents will provide:

- Sunblock / Insect Repellent / Diaper Cream - labeled pls.
- Labeled Blanket for sleeping in a big sealed zip lock bag (labeled)
- Back-up clothes appropriate for changes in weather: pants, shirt, sock, underwear if applicable (labeled and contained in a labeled zip lock bag)
- Updated yearly medicals and immunization records – on the official form issued by the Department of Health
- Daycare Cumulative Health Record (yellow bi-fold form) – indicating any allergies, recurring illnesses, medical tendencies of the child, Early Intervention Plans.
- Updated contact phone numbers at all times – ** parents are required to keep Honeydew updated of any changes. We must be able to reach you at all times – and if we leave a message, we need a call back within the hour.
- Timely pickup of your child or late fee charges will be incurred.
- Parent Handbook forms – filled out, signed and returned to Honeydew

Parents are required to read the entire Parent Handbook for our curriculum, activities, policies, emergency procedures and contact numbers.

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 _____ Cell _____ Work _____

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

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
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
☐ ***Addendum attached.***

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

☐ None ☐ Yes *(list below)*

_____
_____
_____
_____

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	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	

Tdap	___/___/___	___/___/___	___/___/___		
MMR	___/___/___	___/___/___	___/___/___		
Varicella	___/___/___	___/___/___	___/___/___		
Mening ACWY	___/___/___	___/___/___	___/___/___		
Hep A	___/___/___	___/___/___	___/___/___		
Rotavirus	___/___/___	___/___/___	___/___/___		
Mening B	___/___/___	___/___/___	___/___/___		
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#