OLFCA Summer Camp Registration Form 2024

	Child #1	***Child #2***	***Child #3***	***Child #4***
First Name				
Middle Name				
Last Name				
Date of Birth				
Gender	**M F**	**M F**	**M F**	**M F**
Grade in September '24	**1 2 3 4 5 6 7**	**1 2 3 4 5 6 7**	**1 2 3 4 5 6 7**	**1 2 3 4 5 6 7**
Sessions (Circle Session Attending) **				

** Please Note Dates for Each Session (**and see attached flyer for Activities Schedule**):

Session 1: 6/24/2024 - 6/28/2024

Session 2: 7/1/2024 - 7/5/2024

Session 3: 7/8/2024 - 7/12/2024

Session 4: 7/15/2024 - 7/19/2024

Session 5: 7/22/2024 - 7/26/2024

Session 6: 7/29/2024 - 8/2/2024

Session 7: 8/5/2024 - 8/9/2024 **

KIDS SUMMER FUN CENTER
AT OLFCA
25-38 80TH Street
Jackson Heights, NY 11370
718-429-7031

MONDAYS-FRIDAYS
JUNE 24-AUGUST 11
7:30 AM TO 6:00 PM

ALL ARE WELCOME
Ages 4-12

(Late Pick-Up fee: $1 per minute)

ACTIVITIES

- Arts & Crafts
- Playground
- Educational Enrichment
- Water Play
- iPads
- Sports/Cooperative Play
- Learning Opportunities
- Push in programs

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CAMP WEEKS

JUNE 24-28 JULY 1-5 (CLOSED 7/4&7/5) JULY 8-12 JULY 15-19
JULY 22-26 JULY 29-AUGUST 2 AUGUST 5-9

Early Bird Discount rate of $280 per week available if you register before April 30.

Regular Registration Begins April 28: $300 per week

	1 child	2 children	3 children
Full day 7:30-6:00/Daily Rate	$70	$105	$130
Full day 7:30-6:00/Weekly Rate	$300	$450	$525
Half day 9-3:00/Daily Rate	$50	$75	$95
Half day 9-3:00/Weekly Rate	$210	$315	$380
Summer School Rate (for students attending classes 6/26-7/18)	$150	$225	$300
Registration fee	$75	$125	$175

**daily after care rate $25/day (3pm-6pm)
**summer school/camp registration fee $25

Payment must be paid before the child can attend each week
No Exceptions

NYC Free School Breakfast & Lunch Available Daily

No Children under 4
4 year olds must have previous school experience

stationerytree.com

Required Registration Documents: Birth Certificate and Physical Exam (Physical must be dated within one year). Required Documents can be emailed to: summercamp@ourladyoffatimaschool.org

Payment ($75 Registration Fee):
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- ***Money Order:*** Mail to Our Lady of Fatima Catholic Academy ("Attn: Summer Registration") , Address: 25-38 80th street, Queens, NY 11370
- ***Cash:*** Must Register In Person
- ***Credit Card:*** Call Our Lady of Fatima Catholic Academy, Phone Number: (718) 429-7031

Parent/Legal Guardian #1:

First and Last Name: ____

Address(If Different from Child): ____

Home Phone: _______________ Work Phone: ________________ Cell Phone: ________________

Email(**Required for Communication Reminders/Updates***) _________________________________

Employer: ____

Employer Address: ____

Employer Phone: ___________________________________

Parent/Legal Guardian #2:

First and Last Name: ____

Address(If Different from Child): ____

Home Phone: _______________ Work Phone: ________________ Cell Phone: ________________

Email(**Required for Communication Reminders/Updates***) _________________________________

Employer: ____

Employer Address: ____

Employer Phone: ___________________________________

Emergency Contacts:

1) Name: _________________________ ***Phone Number:*** ______________________

Relationship to Child: ________________________

2) 1) Name: _________________________ ***Phone Number:*** ______________________

Relationship to Child: ________________________

3) 1) Name:_________________________ Phone Number:______________________

Relationship to Child:________________________

Please detail here any specific custody agreements or people that are not authorized to pick up your children:

____
____
____
____
____
____

Any Additional Information:

____
____
____
____
____
____

______(Initial Here): I understand that at no time are the counselors at Our Lady of Fatima Summer Camp allowed to change or touch the campers at any time. We are not allowed to change clothes or take care of toileting accidents. We are not permitted to have contact with the campers in this way.

I have read and agree to all conditions of this registration.

Parent Signature:_______________________________________

Date:_________________________

Photo Permission:

I hereby give consent to Our Lady of Fatima Summer Camp ("the organization") to photograph, videotape, or otherwise digitally record and use images and/or sound recordings of myself or my child/children to use in any public media, including radio, television, internet, social media, or print.

Child's(Children's) Name:____

Parent Signature:____

OLFCA SUMMER CAMP 2024

A VARIETY OF NEW GAMES & ACTIVITIES ADDED!

NEW & IMPROVED PROGRAM!

DIRECTORS: MRS. LOMBARDO & MS. STAFFORD

FULL DAY: 7:30-6:00 | HALF DAY: 9:00-3:00

MONDAYS	TUESDAYS	WEDNESDAYS	THURSDAYS	FRIDAYS
-PERLAR BEADS	-YOGA	-MUSIC & MOVEMENT	-OBSTACLE COURSE	-RELAY RACE
-EDUCATION	-EDUCATION	-EDUCATION	-EDUCATION	-I PAD
-COOKING CLASS	-SOCCER	-LEGOS	-KICKBALL	-ORIGAMI
-PLAY DOUGH / SLIME	-PAINTING	-PLAYGROUND	-ARTS & CRAFTS	-DIAMOND ART
-KINETIC SAND	-I PAD	-BASKETBALL	-BOARD GAMES	-ZUMBA
-WATER SLIDE	-POTTERY	-STEM	-T BALL	-OUTDOOR PLAY (SAND / WATER TABLES, BUBBLES,CHALK ETC.)
-TABLE TOP SPORT GAMES	-PLAYGROUND	-ACTIVE FLOOR	-TABLE TOP SPORT GAMES	-JEWELRY
-OUTDOOR PLAY (SAND / WATER TABLES, BUBBLES,CHALK ETC.)		-BOUNCE HOUSE	-PLAYGROUND	-WATER PLAY

NYC FREE LUNCH PROVIDED DAILY

OUR LADY OF FATIMA CATHOLIC ACADEMY

25-38 80TH STREET EAST ELMHURST, NY 11370

(718) 429-7031 WWW.OLFCAQUEENS.ORG

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 ☐ Foster Parent | Last Name | First Name

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 medications: ☐ Inhaled corticosteroid ☐ 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:

Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	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)		☐ Nl ☐ 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

Vaccine	Dates
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:

CH-205 (5/08) *Copies:* White School/Child Care/Early Intervention/Camp Canary Health Care Provider, Pink Parent/Guardian