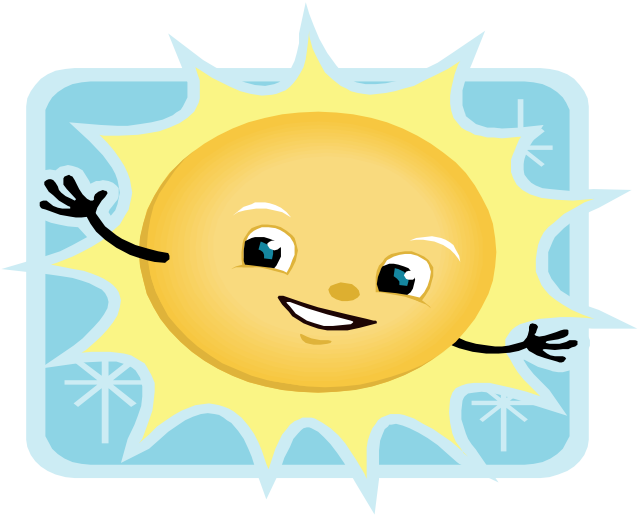
Bronx Baptist Church
331 East 187th Street – Bronx, NY 10458
Tel. (718) 933-4095 email: bbcoffice@aol.com

SUMMER DAY CAMP



Ages 5 – 11 years (Boys and Girls)
MONDAY – FRIDAY 8:00 A.M. – 6:00 P.M.
(Extended day services available)

ACTIVITIES: Trips! Sports! Music! Movies!
Arts & Crafts and lots more!!!

BRONX BAPTIST CHURCH DAY CAMP
331 East 187th Street
Bronx, NY 10458

Dear Parent/Guardian:

It's that time again when we look forward to all the fun and excitement of summer camp. As usual we have lots of outdoor activities planned for the children, and we look forward to your continued support.

The camp will be opened each day Monday to Friday from 8:00 a.m. – 6:00 p.m.

We look forward to a fun filled and exciting summer with your child/children this summer.

Sincerely yours
BRONX BAPTIST CHURCH

BRONX BAPTIST CHURCH

331 East 187th Street • Bronx, NY 10458 • Tel. 718-933-4095 • email: bbcoffice@aol.com
Rev. Frank I. Williams, Pastor

APPLICATION FORM

NAME OF CHILD: _____

AGE: _____ DATE OF BIRTH: _____ GENDER: ☐ Male ☐ Female

ADDRESS: _____ APT # _____

CITY: _____ STATE: _____ ZIP: _____

TEL: HOME_____CELL _____ JOB _____

EMAIL_____

PRESENT SCHOOL: _____

GRADE: _____ NAME OF TEACHER: _____

PARENTAL INFORMATION

MOTHER'S NAME: _____ EMAIL: _____

NAME OF GUARDIAN: _____
(if parents are not available)

TEL#: _____ _____ _____
Home Job Cell

FATHER'S NAME: _____

TEL#: _____ _____ _____
Home Job Cell

WHAT SHOULD WE KNOW ABOUT YOUR CHILD? _____

_____

_____

_____

PHYSICAL CONDITION OF YOUR CHILD: (hearing, vitality, sight, any physical impairment)

_____

_____

IS YOUR CHILD ON MEDICATION? ☐ Yes ☐ No

IF YES, PLEASE STATE: _____

_____

_____

_____

_____

CONTACT PERSONS IN CASE PARENTS CANNOT BE REACHED:

NAME: _____ Relationship to Child: _____

ADDRESS: _____

DAY PHONE#: _____ CELL#: _____

NAME: _____ Relationship to Child: _____

ADDRESS: _____

DAY PHONE#: _____ CELL#: _____

NAME: _____

SIGNATURE: _____ DATE: _____

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 medication(s): ☐ 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/m^2 (___ %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

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 ___/___/___

DOHMH ONLY PROVIDER I.D.

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

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

Comments

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Date Reviewed: ___/___/___ I.D. NUMBER

Telephone ( ) ___ – ___ | Fax ( ) ___ – ___

REVIEWER:

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

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
DIVISION OF ENVIRONMENTAL HEALTH
BUREAU OF FOOD SAFETY AND COMMUNITY SANITATION
253 BROADWAY, 12TH FLOOR CN 59A
NEW YORK, NY 10007
(212) 676-1600

Below is the recommended written statement that must be provided by each camp to all parents or guardians declaring that the camp is licensed by the New York City Department of Health and Mental Hygiene. (NYCHC Section 48.29)

PARENT INFORMATION STATEMENT

BRONX BAPTIST CHURCH
SUMMER DAY CAMP 23359
331 EAST 187TH STREET, BRONX, NY 10458

This camp is licensed by the New York City Department of Health and Mental Hygiene and is inspected twice yearly. The inspection reports are filed at the Bureau of Food and Safety Community Sanitation.

DCR 21 (Rev. 1/04)