15 Neil Court
Oceanside, NY 11572
Phone: (516) 766-4341
Fax: (516) 766-0513
E-mail: camp@friedbergjcc.org
Web: www.friedbergjcc.org

Summer 2017

Dear Camp Friedberg Families,

We are thrilled that your child(ren) will be with us this summer and are looking forward to a fabulous camp season! Camp orientations are the perfect time for parents to meet the administration staff of your child's camp division and ask all the questions you may have concerning their individual summer program. In addition, itineraries for overnight trips will be discussed in detail when applicable.

T-shirts, sweatshirts, and additional camp accessories will be available for sale on each night of orientation at 6:00 pm. Each child will receive two free camp T-shirts, but we recommend that you purchase additional shirts because **campers are required to wear them every day**. We suggest that you arrive as early as possible in order to pick up your 2 free shirts and to purchase any additional items.

All orientations are held at the Friedberg JCC, 15 Neil Court, Oceanside unless noted differently.

Parent Orientation schedule is as follows:

Long Beach Early Childhood ***Location: 310 National Blvd. Long Beach***	(ages 2-5)	Monday, June 12th	***6:30 pm***
Voyagers Division	(grades 7-10)	Monday, June 12th	***7:30 pm***
Explorers Division	(grades 5-6)	Tuesday, June 13th	***7:00 pm***
Junior Division Orientation ***New date & time***	(grades K-4)	Monday, June 19	***7:30 pm***
Junior Division Meet your Counselor Night	(grades K-4)	Wednesday, June 21st	***6:30 pm - 8:30 pm***
Oceanside Early Childhood	(ages 2-5)	Monday, June 19th	***6:30 pm***
Camp Achieve	(grades K-8)	Tuesday, June 20th	***7:00 pm***
Merrick Early Childhood ***Location: 225 Fox Blvd., Merrick***	(ages 2-5)	Wednesday, June 21st	***7:30 pm***
Theatre/Art Divisions	(ages 5-13)	Thursday, June 22nd	***7:30 pm***

We would like to thank you again for the opportunity to share this summer with your children. Please feel free to contact me if you have any questions.

Warm regards,

Lori Innella-Venne
Program Director
(516) 634-4177
linnellavenne@friedbergjcc.org

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☐ **Voyagers** ☐ **CIT** ☐ **Theatre/Art** ☐ **Achieve**

MEDICAL AUTHORIZATION FORM

(TO BE COMPLETED BY PARENT/GUARDIAN)

This authorization form is to be carried by the Director and will be used only if we have attempted to reach you and are unable to do so. This form is for emergency use only and will never be used without first trying to contact you.

In case of an emergency, I hereby authorize the doctor or the hospital to which my child or children may be brought (and whomever they may designate or their assistants) to perform any emergency procedures or operations, to give treatment and the administration of anesthetics to my child.

Camper's Full Name _____ Date of Birth: _____

Home Address_____Town_____State/Zip _____

Parent/Guardian 1 Name_____ Bus. Phone _____ Cell _____

Parent/Guardian 2 Name_____ Bus. Phone _____ Cell _____

Emergency Contact 1, Relationship & Phone _____

Emergency Contact 2, Relationship & Phone _____

Physician's Name & Phone _____

Allergies_____

Medications _____

Does family have insurance? Yes ☐ No ☐ Coverage: Mother ☐ Father ☐ Parent's SSN: _____

Health Insurance Co. & Policy # _____

_____

I authorize any physician, nurse, or health care provider, to communicate with the medical staff and director of Camp Friedberg or his/her designee about my child's medical condition treatment and/or prognosis.

I further authorize the camp medical staff to discuss any medical conditions with the director, his/her designee, or my child's counselor when the medical staff, in its sole discretion, believes such communication to be in the best interest of my child.

These authorizations are limited to June 26, 2017 through August 31, 2017.

Parent or Guardian's Signature_____ **Date:** _____

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CAMPER PROFILE

Camper's Photo Here

Please Do NOT Staple

Camper's Full Name _____

Grade in September 2017_____

My child would like to be grouped with: _____

_____

My child's favorite activities are: _____

_____

In order for your camper to have the most successful camp experience, please answer the following:

1. My child has special dietary needs or food allergies: Yes ☐ No ☐

If yes, please explain: _____

_____

2. My child meets other children with ease? Yes ☐ No ☐

3. My child is allergic to certain plants, animals, drugs, stings: Yes ☐ No ☐

If yes, please list the allergies that your child has and any medications or inhalers that he/she uses:

_____

_____

4. My child will need to receive medication at camp? Yes ☐ No ☐

If yes, please name the medication, dosage, and time of medication. A physician's letter, copy of the prescription and original bottle/packaging will be required: _____

_____

_____

5. My child has an IEP or 504 plan? Yes ☐ No ☐

If yes, please share a copy of this with your child's camp director prior to the first day of camp. This will help us to ensure the most successful experience for your child this summer.

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CAMPER PROFILE (continued)

Camper's Full Name _____

6. My child receives the following services during the school year (please check all that apply):

Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐

Early Intervention Services ☐ Behavior Intervention Planning ☐ Social Skills Training ☐

Other ☐ (please explain) _____

_____

7. My child will be wearing the following at camp (please check all that apply):

Eye Glasses ☐ Contact Lenses ☐ Braces ☐ Hearing Aid(s) ☐ Insulin Pump ☐

Other ☐ (please explain) _____

_____

8. My child can swim in deep water? Yes ☐ No ☐

9. My child has taken swimming lessons/classes? Yes ☐ No ☐

10. My child feels comfortable in the water? Yes ☐ No ☐

11. My child will be attending the before/after camp program? Yes ☐ No ☐

12. My child has slept away from home before? Yes ☐ No ☐

13. Please tell us anything you think we should know about your child. The more information you share with us, the better we will know your child before camp even starts!

_____

_____

_____

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SWIM INTAKE & PERMISSION SLIP

I give permission for my child, _____, to swim on and off camp premises for the summer 2017 camp season.

Age as of June 26, 2017:_____ Grade entering in September 2017:_____

Please check the statement below that most closely represents your child regarding his/her swim ability:

- ☐ My child is very comfortable in the water. There are no restrictions. I encourage full participation and expect him/her to learn new skills.
- ☐ My child enjoys being in the water but needs some positive reinforcement during instruction. I hope that he/she gains confidence in his/her swimming skills this summer.
- ☐ My child sometimes needs a little reassurance to overcome his/her anxiety about swimming.
- ☐ My main objective is for my child to feel comfortable in the water; skill acquisition is not one of my highest priorities. I am hoping that my child will leave camp with a positive attitude towards swimming.

Please indicate the most recent American Red Cross level that your child has completed. If you do not know this information, please check the swim level that best describes your child:

American Red Cross card level: _____ or camper's swim Level:

Circle One: Non-swimmer Beginner Intermediate Advanced

Additional comments regarding swim:_____

_____

_____

_____

All campers are swim tested on the first day of camp. This form will be given to our aquatics staff so that we can design and implement an appropriate swim program for your child.

Parent or Guardian's Signature_____ Date: _____

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PICK-UP PERMISSION FORM

I, _____, hereby give permission for my child,
(Parent/Guardian Name)

_____ to be picked up by the following people:
(*Camper Name*)

NAME	**PHONE #**	**RELATION**
1.		
2.		
3.		
4.		

I understand that anyone on the pick-up list must present proof of identification (driver's license, picture ID, etc.) before they may leave the JCC/camp/bus with my child.
All changes MUST be provided in writing.

Parent or Guardian's Signature_____ **Date:** _____

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CAMPER MEDICAL FORM

(THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN)

Child's Full Name: _____
Address _____ City/State/Zip _____
Birthdate_____ Age_____ Sex_____ Home Phone _____
Parent/Guardian 1 Name_____ Cell _____ E-mail: _____
Parent/Guardian 2 Name_____ Cell _____ E-mail: _____
Emergency Contact Name & Phone _____
Health Insurance Name & Policy # _____
Policy Holder's Name _____
Other Heath Insurance & Policy # _____

I. HEALTH HISTORY

(THIS SECTION TO BE COMPLETED BY PHYSICIAN)

☐ Abscessed Ears	☐ Diabetes	☐ Measles	☐ Polio
☐ Asthma	☐ Fainting	☐ Motion Sickness	☐ Rheumatic Fever
☐ Athlete's Foot	☐ Frequent Colds	☐ Mumps	☐ Sinusitis
☐ Bronchitis	☐ German Measles	☐ Poison Ivy	☐ Stomach Upset
☐ Chicken Pox	☐ Heart Trouble	☐ Poison Oak	☐ Tuberculosis
☐ Convulsions			☐ Whooping Cough

Operations/Serious Illnesses/Injuries? Yes ☐ No ☐ If Yes, list:_____

_____

Is child taking any medication? Yes ☐ No ☐ If Yes, list name(s) of medication(s)/treatment(s):

_____

Food allergies? Yes ☐ No ☐ If Yes, list: _____

_____

Allergic reactions (e.g. bee stings, penicillin, other drugs?) Yes ☐ No ☐ If yes, list:_____

_____

_____

If child is female, has she begun menstruation? Yes ☐ No ☐ If yes, date began:_____
Specific activities to be encouraged _____
Specific activities to be restricted _____

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Childs's Full Name _____

II. PHYSICAL EXAM & IMMUNIZATIONS

(THIS SECTION TO BE COMPLETED BY PHYSICIAN)

PHYSICIAN MAY ATTACH PRINTOUT OF MOST RECENT PHYSICAL EXAM AND IMMUNIZATION RECORD

PHYSICAL EXAM MUST BE WITHIN 1 YEAR OF LAST DAY OF CAMP

_____ Satisfactory _____ Unsatisfactory Explain: _____

_____ Height	_____ Blood Pressure	_____ EGB Test	_____ Lungs
_____ Weight	_____ Extremities	_____ Posture	_____ Hernia
_____ Eyes	_____ Ears	_____ Glasses	_____ Abdomen

Recommendations and/or restrictions (diet, medicine, etc.) _____

_____

_____

_____ DPT Series or DT	_____ Date	_____ Booster Date
_____ Polio Series	_____ Date	_____ Booster Date
_____ Typhoid Series	_____ Date	_____ Booster Date
_____ MMR	_____ Date	
_____ Tetanus Booster	_____ Date	
_____ Diphtheria	_____ Date	
_____ Varicella	_____ Date	
_____ Smallpox	_____ Date	
_____ Hemophilus B Vaccine (HIB)	_____ Date	
_____ Hepatitis B	_____ Date	

Physician's Name: _____

Date of Examination: _____

Office Address: _____

Phone: _____ Fax: _____

Physician's Signature: _____

IF RETURNING THIS FORM DIRECTLY TO CAMP OFFICE, PLEASE FAX TO: (516)766-0513