Hello Campers & Parents!

Welcome to the Summer SPLASH Camp! Please come to our Camp Orientation so you can meet your counselors and hear about the exciting summer we will have together. All forms are due by June 1st and are included with this packet; they may also be found on our website at gsplainview.org. All forms can be scanned and emailed to us at contact@gsplainview.org. (except for the green emergency contact card). We must have all forms before the first day of camp or your child WILL NOT be able to attend.

Here is some information you will need:

SNACKS/LUNCHES: Parents must pack two snacks and a lunch for full-day campers and one snack for half day campers. This camp is **peanut/tree nut-free** and because many children are severely allergic, we must strictly adhere to this rule. Parents do not have to pack a lunch on Thursdays, because every Thursday is pizza day and pizza is provided for lunch!

SUNSCREEN: Parents must apply sunscreen every morning before children arrive at camp. If parents want camp staff to reapply sunscreen during the day, they must sign the Sunscreen Permission Form and send in the sunscreen in a labeled Ziploc bag.

WATER PLAY: Please wear the bathing suit under outer clothing daily and place other essential clothing for the day (underwear, etc.) in a labeled Ziploc bag for after water play. Children must have water shoes for water play; absolutely no flip flops can be worn for safety reasons. Children from ages three-up will have separate changing areas for girls and boys.

BEFORE/AFTER CARE: If parents need for campers to arrive earlier than 9:00 AM or stay after 3:00 PM, we provide before-care from 7:00 – 9:00 AM and after-care from 3:00 – 6:00 PM. The charge is: Toddlers $11.50/hr. and Nursery – School Age, $9.50/hr. Parents are billed for before/after care at the end of July and August; payment is expected ten days after the bill is received via email or a $25 late fee charge will be added.

NECESSARY FORMS FOR Summer SPLASH CAMP: 1) Green Emergency Contact Card, 2) Medical/Immunization Form, 3) Confidential Parent Questionnaire, 4) Sleeping and Napping Agreement (except for school age children), 5) Permission to Apply Sunscreen Form, 6) Permission Slip to Go to Church Building, 7) Permission Slip to Take Child Off Premises (this form is only for infants or toddlers in the stroller).

Campers are going to have a great summer doing weekly themed- activities along with playing many games, hearing stories, enjoying arts & crafts, gardening, music, sports, cooking, and science, not to mention getting all wet at water play. We also have many special guests for the summer including Busto's Karate, the Fun Bus, Jump Bunch, a Petting Zoo, a Balloon Animal Artist, a Magician, and a real DJ!

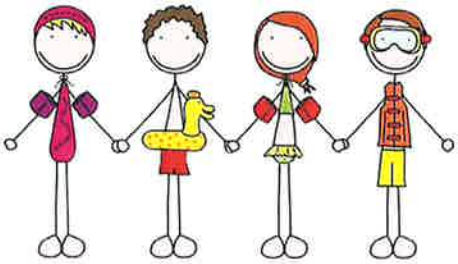
We hope all other questions you have will be answered at the Summer SPLASH Camp Orientation. We look forward to meeting you then!

Good Shepherd Lutheran Church and School

99 Central Park Road, Plainview, N.Y. 11803
(516) 349-1966
www.gsplainview.org

The 2019 Summer SPLASH Camp Orientation will be on June 21st at 6:00pm.

We hope to see you all there!



Good Shepherd Lutheran Splash Camp

Summer Supply List

- A complete change of clothing in a large Ziploc bag, which will be left in the classroom (include underpants, socks, shirt and shorts)
- Baby Wipes
- Peanut/Treenut free lunch for Full Day Campers (except for Thursday, pizza day!)
- Peanut/Treenut free Snacks: Full Day 2 snacks, Half Day 1 snack
- Sunblock Labeled in Ziploc bag
- Water shoes for water play: crocs or canvas (NO FLIP FLOPS)
- Wear bathing suit daily under clothing!
- A package of gallon Ziploc bags for wet swimsuits & towels to go home daily
- Wear sneakers daily!
- Bring towel daily!
- Crib size sheet and a blanket for Toddler/Nursery & Pre-K
- Kindergarten & School Age children, please provide summer reading books for quiet time
- A pocket folder for notices sent home
- A camp bag and water bottle will be given on the first day

*** Everything MUST be labeled**

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Before and After Care Form

CHILD'S NAME: _____

CHILD'S CLASS: _____

BEFORE CARE 7-9 a.m.

Hours desired: (Indicate days and drop off times)

Monday_____

Tuesday_____

Wednesday_____

Thursday_____

Friday_____

AFTER CARE 3-6 p.m.

Hours desired: (Indicate days and pick up times)

Monday_____

Tuesday_____

Wednesday_____

Thursday_____

Friday_____

Please Note the following policy regarding pick up after program closes:

*Any After Care pick up after 6pm is charged as follows:
Toddler: $1/minute
Nursery-Grade 6: $10/15minutes

CHILD CARE AGREEMENT:

I understand and agree to be billed for the designated hours at the rate of Toddler: $11.50/hour. Nursery-Grade 6: $9.50/hour. Please note that should payment not received by the 10th of the month a late fee will be assessed. The late fee is $25.00 or 5% of the payment due, whichever is greater.

_____ _____

Parent/Guardian Date

For your convenience, childcare is also available on an as-needed basis.
Please call the office at 516-349-1966.

Good Shepherd Lutheran School Health Examination Form

Child's Name: _____ Date of Birth _____ Class _____
Last First

PHYSICIAN COMPLETE (*Actual Readings)

*Height:	*Blood Pressure: *Pulse:
*Weight:	Abdomen
Hearing Screening:	
Vision: w/glasses _____ w/o glasses _____	Heart:
Nose & Throat:	Lungs:
Mouth & Teeth:	Urinalysis: Sugar _____ Protein _____ Blood _____
Skin:	Orthopedic: *Scoliosis
Allergies: _____ Seasonal _____ Asthma _____ Life Threatening _____ Medication	
* BODY MASS INDEX*	
WEIGHT STATUS CATEGORY (BMI) PERCENTILE: _____ Less than 5% _____ 5th through 49th% _____ 50th through 84th% _____ 85th through 94th% _____ 95th through 98th% _____ 99th and higher	

Specify current diseases: ☐ Asthma ☐ Diabetes type 1 ☐ Diabetes type 2 ☐ Cholesterol ☐ Hypertension

Is child free from communicable diseases? Yes___ No___ If no, please specify:_____
May student participate in physical education activities? Yes___ No___
Recommendations for adjustment of school program: _____
Does student require medication? Yes____ No____ If yes, please specify: _____

Physician's Signature _____

Physician's Stamp

Actual Date of Physical

_____

IMMUNIZATIONS AND TESTS

IMMUNIZATION	DATE 1ST DOSE	DATE 2ND DOSE	DATE 3RD DOSE	DATE 1ST BOOSTER	DATE 2ND BOOSTER
Polio					
dtap					
Tdap or td					
mmr					
measles					
mumps					
rubella					
Hib					
Hep b					
Hep a					
varicella					
pneumococcal					
ppd (Tuberculin)					
Meningococcal vaccine					
Other					
other					
Legal requirement for immunization waived because of: religious exemption ☐ medical exemption ☐					

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Confidential Parent Questionnaire

Please complete this questionnaire so your child's teacher will have a better understanding of your child and his/her needs or concerns.

Full Name _____
Last First M.I.

Name you want child called in school _____

Class _____ Date of Birth _____ Sex M ____ F ____

Brother's and Sister's name(s) and birth date(s) _____

_____

_____

Does your child speak English? Yes __ No __ If no, what language _____

Does your child understand the English language? Yes __ No __

Describe your child's interest(s). _____

_____

How does your child interact with other children? _____

_____

_____

Describe your child's personality traits: _____

_____

_____

How do you think your child will react to the first day of school? _____

_____

_____

(Continued on Reverse Side)

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Has there been a change in family status that might possibly affect your child? (i.e. new baby, death of a close relative, separation, divorce, any chronic disease, move etc.)

Is there any emotional condition that might possibly cause a problem in school?

Does your child have any fears? Please explain.

Did your child have any physical condition(s) worth mentioning during the last year? (i.e. diseases, accidents, operations, hospitalization, special examinations, hearing or speech defects, prescription glasses, immunizations, allergies, etc.)

Is your child on any prescribed medications? No ____ Yes ____ which one(s)

Is your child currently receiving any early intervention services? No _____ Yes _____ (i.e. SEIT, physical/occupational therapy, etc.) Please list services.

Do you have any additional thoughts you wish to share?

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SLEEPING AND NAPPING AGREEMENT

Sleeping and napping arrangements must be in writing between the parent and the child care provider. This arrangement is required by the New York State Office of Children and Family Services.

I, (parent name) _____, understand that my child, _____, while under the care of Good Shepherd Lutheran School, will be napping on a cot or crib in my child's classroom.

My napping child will have competent supervision at all times through direct supervision by a caregiver who is in the same room and has direct visual contact with him/her.

If my child is an infant, I also understand that my child will be placed on his/her back to sleep.

Parent Signature: _____

Child's Name: _____ Teacher's Name: _____

Date: _____ School Year: _____

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PERMISSION TO APPLY SUNSCREEN FORM

Please sign this form if you would like for us to apply sunscreen during the day. In order to keep things organized we kindly ask that you put the sunscreen bottle in a labeled zip-lock bag.

I would like to have sunscreen applied to my child_____

Signature x_____ Date: _____

GOOD SHEPHERD LUTHERAN CHURCH & SCHOOL
99 Central Park Road, Plainview, N.Y. 11803
(516) 349-1966
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PERMISSION SLIP TO TAKE CHILD TO CHURCH BUILDING

_____ has my permission to go with his/her class to the church building on campus to attend music classes and chapel. Chapel is held each Tuesday at 9:30 AM and music classes are built into your child's weekly schedule. The appropriate class ratio is maintained at all times (6 weeks to 18 months, 4:1 staff members; 19 – 36 months, 5:1 staff members; three years old, 7:1 staff members; four years old, 8:1 staff members; five years old, 9:1 staff members; and over five years old, 10:1 staff members).

I understand the faculty and staff will supervise my child with the utmost care and concern as he/she goes from the school building to the church building.

_____ _____
Signature of Parent/Guardian **Date**

For the safety of your child, please fill out the below, since the teachers will take these forms with them when they leave the main school building.

HEALTH HISTORY

Allergies: _____

Special Medical Conditions: _____

Medications: _____

Other: (Eyeglasses, etc.) _____

Physician contact: _____ _____
(name) **(phone)**

Emergency Contact: _____ _____
(name) **(phone)**

GOOD SHEPHERD LUTHERAN CHURCH & SCHOOL
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PERMISSION TO TAKE CHILD OFF PREMISES

_____ has my permission to go in the stroller with the class off the church and school premises. This would include going down Central Park Road and up the hill to the Good Shepherd Houses for the purpose of entertaining the children and having them get some fresh air. The class would be in the appropriate ratio at all times (6 weeks to 18 months, 4:1 staff members; 19 – 36 months, 5:1 staff members).

I understand the faculty and staff will supervise my child with the utmost care and concern.

_____ _____
Signature of Parent/Guardian **Date**

For the safety of your child, please fill out the below, since the teachers will actually take these forms with them when they go for an excursion.

HEALTH HISTORY

Allergies: _____

Special Medical Conditions: _____

Medications: _____

Other: (Eyeglasses, etc.) _____

Physician contact: _____ _____
(name) **(phone)**

Emergency Contact: _____ _____
(name) **(phone)**

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

You may use this form or an approved equivalent to document an individual health care plan developed for a child with special health care needs.

A child with a special health care need means a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.

Working in collaboration with the child's parent and child's health care provider, the program has developed the following health care plan to meet the individual needs of:

Child Name:	Child date of birth:
Name of the child's health care provider:	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner

Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.

Identify the caregiver(s) who will provide care to this child with special health care needs:

Caregiver's Name	Credentials or Professional License Information (if applicable)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Describe any additional training, procedures or competencies the caregiver identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

This plan was developed in close collaboration with the child's parent and the child's health care provider. The caregivers identified to provide all treatments and administer medication to the child listed in the specialized individual health care plan are familiar with the child care regulations and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Program Name:	License/Registration Number:	Program Telephone Number:
Child care provider's name (please print):		Date:
Child care provider's signature: **X**		

Signature of Parent:

X	Date:

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

WRITTEN MEDICATION CONSENT FORM

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.
- This form or an approved equivalent may be used when written consent to administer medication to a child is required from both the Licensed Authorized Prescriber and the Parent.

LICENSED AUTHORIZED PRESCRIBER MUST COMPLETE THIS SECTION (#1 - #18)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of medication (including strength):	5. Amount/dosage to be given:	6. Route of administration:

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) _____

8A. Possible side effects: ☐ See package insert for complete list of possible side effects (parent must supply)

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

☐ Contact parent ☐ Contact prescriber at phone number provided below

☐ Other (describe): _____

10A. Special instructions: ☐ See package insert for complete list of special instructions (parent must supply)

AND/OR

10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____

11. Reason for medication (unless confidential by law): _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete #33-#34 on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete #35-#36 on the back of this form.

14. Date prescriber authorized:	15. Date to be discontinued or length of time in days to be given *(this date cannot exceed 6 months from the date authorized or this order will not be valid)*:
16. Prescriber's name (please print):	17. Prescriber's telephone number:

18. Licensed authorized prescriber's signature:

X

OCFS-LDSS-7002 (5/2014) REVERSE

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

WRITTEN MEDICATION CONSENT FORM

PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the prescriber write 12pm?)* ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the child day care program is to administer the medication (i.e.: 12pm): _____

20. I, the parent, authorize the day care program to administer the medication as specified herein.

21. Parent or legal guardian's name (please print):	22. Date authorized:

23. Parent or legal guardian's signature:
X

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#24 - #30)

24. Provider name:	25. license/registration number:	26. Program telephone number:
Good Shepherd Lutheran School	00044258 DCC	516-349-1966

27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Child care provider's name (please print):	29. Date received from parent:
Teresa Ratkowski	

30. Child care provider's signature:
X

ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

31. I, parent, request that the medication indicated on this consent form be discontinued on _____ (date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:
X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Licensed Authorized Prescriber's Signature:
X

35. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

DATE:

By completing this section the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

36. Licensed Authorized Prescriber's Signature:
X