KidzConnect Summer Day Camp

First Baptist Church of Flushing
142-10 Sanford Avenue, Flushing, NY 11355
Tel.: (718) 539-6822 | Fax: (718) 939-9136
sdc@fbcflushing.org | fbcflushing.org/camp

February 2024

Dear Parents/Guardians,

We extend a warm welcome to our returning camp families and to the new families joining us for the first time! We have been serving the Flushing community for over 25 years. At KidzConnect, we strive to provide an enriching program where kids have fun while learning new things, all in a safe environment with qualified teachers and small classes.

Here are some highlights for 2024:

- ✓ $100 discount if paid in full by May 31
- ✓ Fun Fridays: Improv workshops, Trips, Carnival!
- ✓ Chess elective for grades 2-8
- ✓ Robotics for grades 6-8

Our theme this year is from Psalm 139:14a: **"I praise you because I am fearfully and wonderfully made..."** From various Bible stories, the children will learn that God created them for a purpose and that they are precious and loved by Him.

TO REGISTER:

1. Complete registration packet
    a. Registration Form (both sides – signature required)
    b. Trip/Code of Conduct Form (both sides – signature required)
    c. DOH Health Form **(Must be completed by a health care practitioner. Children will NOT be admitted to the Camp without it.)**
2. Submit completed packet with full payment (cash, money order or check) by May 31 for the early bird discount.

    Send your registration packet with your payment to the church address **OR** register in person Monday-Friday during office hours. Checks must be payable to "First Baptist Church of Flushing." Write "Summer Day Camp" in memo portion. Your full payment reserves your child's spot in the Camp.

If you have any questions, please do not hesitate to contact us at 718-539-6822 ext. 1002. Dial ext. 1001 if you wish to speak to an administrator in Chinese or ext. 1000 for Spanish.

Please tell your friends and relatives about our Camp! We look forward to a wonderful summer with your children!

Sincerely,

Carol Tom

Carol Tom
Children's Minister

FIRST BAPTIST CHURCH OF FLUSHING (FBCF)

142-10 Sanford Avenue, Flushing, NY 11355
Phone: (718) 539-6822 · Fax: (929) 264-7311 · fbcflushing.org/camp

KIDZCONNECT SUMMER DAY CAMP (SDC) REGISTRATION FORM

2024 _____

□ Registration Form □ Health Form

STUDENT INFORMATION/學生資料			
1.First Name/名	2.Last Name/姓	3.Date of Birth (mm/dd/yy) 出生日期(月/日/年)	4.Age/年齡
5.Address/地址			
6.Sex/性別	7.Native Language/常用語言	8.Grade in Sep. 2024 2024 年九月就讀級別	9. T-shirt size/T 恤呎碼 YXS YS YM YL S M L XL XXL
10.Medical Conditions/健康狀況		11.Allergies/過敏	
12.Child has an IEP? □ Y □ N **Submit a copy of IEP diagnosis/assessment.** 學生有沒有參加個人特別教育方案 IEP? □ 有 □ 沒有 **[請提交個人特別教育方案/報告]**		13.Other information/其他資料	

PARENT/GUARDIAN – 父母/監護人 (Pick-up/Emergency/Billing – 接送/緊急/付費)		
14.Full Name/姓名	15.Relationship to Child/與學生的關係	16.Email/電郵
17.Home Phone/家中電話	18.Work Phone/工作電話	19.Cell Phone/手提電話

SECONDARY CONTACT/第二位聯絡人 (Pick-up/Emergency – 接送/緊急)		
20.Full Name/姓名	21.Relationship to Child/與學生的關係	22.Email/電郵
23.Home Phone/家中電話	24.Work Phone/工作電話	25.Cell Phone/手提電話

ADDITIONAL CONTACTS/其他聯絡人 (Pick-up/Emergency – 接送/緊急)		
26.Full Name/姓名	27.Relationship to Child/與學生的關係	28.Tel. #/聯絡電話
29.Full Name/姓名	30.Relationship to Child/與學生的關係	31.Tel. #/聯絡電話

32. **CHESS ELECTIVE FOR GRADES 2-6:** □ Yes □ No 二至六年級學生可選擇棋藝班: □ 參加 □ 不參加	33. **ROBOTICS FOR GRADES 6-8:** □ Yes □ No 六至八年級學生可選擇機械人班: □ 參加 □ 不參加

OTHER COMMENTS / 其他建議

This camp is licensed by the New York City Department of Health and Mental Hygiene, is inspected twice yearly and includes the address where inspection reports are filed.
此夏令營已於紐約市衛生局登記，並每年兩次接受檢查，已經提交檢查報告。

(TURN OVER AND COMPLETE THE OTHER SIDE) (請繼續填寫背頁資料)

REGISTRATION AGREEMENT

By signing this form, I agree to the following terms and conditions:

1. My child has permission to participate in all the Summer Day Camp activities sponsored by FBCF. I agree to release, indemnify and hold harmless FBCF and its staff from all claims of liability, injury or damage to any person occurring in connection with said Summer Day Camp activities.
2. All fees must be paid in full by May 31 for the discount or the first day of Camp for regular pricing.
3. Health forms must be submitted by June 26, 2024.
4. FBCF has permission to treat my child for minor injuries, such as scrapes and bruises. In the event of an emergency, FBCF has permission to have my child treated at a local emergency room if no authorized contact is reached.
5. FBCF has permission to produce and publish photographs, videos or recordings of my child for lawful purposes at its discretion. I waive all rights, interest or claim for payment for these materials.
6. **REFUND POLICY**: Administrative fee of $30 to process refund. No tuition fees will be refunded if cancelling after 7/19/2024. 50% refund if cancelling between 7/8/2024 and 7/19/2024.
7. There will be no prorating or refund of fees for any missed days or for any other reason.

NAME (PLEASE PRINT) _____

RELATIONSHIP TO CHILD: □ **MOTHER** □ **FATHER** □ **OTHER**_____

SIGNATURE _____**DATE** _____/ _____/ 2024

註冊同意書

簽署此文件後，本人同意以下條文及要求：

1. 本人批準本人的孩子參加法拉盛第一浸信會舉辦的 年夏令營的活動。本人對於因參加該活動而導致本人的孩子有財產損失、個人傷害或損害，本人願意放棄、免除及撤銷對法拉盛第一浸信會及所有工作人員任何的索賠。
2. 所有費用必需在夏令營舉行前繳付，並在 5/31 或之前繳付才可獲折扣優惠。
3. 健康檢查表必需在 6/26/2024 或之前交回。
4. 本人批準法拉盛第一浸信會為本人的孩子處理輕傷，如擦傷或瘀傷。如遇緊急事故，而未能與授權人士聯絡，法拉盛第一浸信會可把本人的孩子送到急症室接受治理。
5. 法拉盛第一浸信會有權製作及發佈本人的孩子的照片、錄像或錄音作任何合法用途。本人放棄這些材料所有權利、利益或索賠。
6. **退款政策：** 7/19/2024 之後退學，所有費用不獲退還。在 7/8 至 7/19/2024 期間退學，可獲退還 50%費用。
7. 不論任何原因，如有缺課將不獲按比列折算或退款。

姓名 (請以正楷填寫) _____

與學生的關係: □ **母親** □ **父親** □ **其他**_____

簽名 _____**日期** _____/ _____/ 2024

FIRST BAPTIST CHURCH OF FLUSHING (FBCF)

142-10 Sanford Avenue, Flushing, NY 11355
Phone: (718) 539-6822 · Fax: (718) 939-9136 · FBCFlushing.org/camp

Camis #: **40583434**
Borough: **Queens**

KIDZCONNECT SUMMER DAY CAMP (SDC)
TRIP ITINERARY & PARENT CONSENT FORM

STUDENT NAME **NOMBRE DEL ESTUDIANTE** 學生姓名			**GRADE** **GRADO** 年級	**AGE** **EDAD** 年齡
(√) Select **Seleccione** 選擇	**DATE** **FECHA** 日期	**TRIP DESCRIPTION** **DESCRIPCIÓN DEL PASEO** 外遊地點	**TRANSPORTATION** **TRANSPORTE** 交通工具	
	7/12	**Movie - Película - 電影 (*Despicable Me 4*)** AMC Bay Terrace 6 211-01 26th Avenue, Bayside, NY 11360	School bus and/or van Bus escolar y/o camioneta 校車 / 教會小巴	
	7/19	**Queens County Farm** 73-50 Little Neck Parkway, Queens, NY 11004	School bus and/or church van Bus escolar y/o camioneta 校車 / 教會小巴	
	7/26	**Improv 4 Kids** 142-10 Sanford Ave., Flushing, NY 11355	N/A	
	8/2	**Laser Bounce (Grades PreK-3)** 80-28 Cooper Ave., Glendale, NY 11385	School bus and/or church van Bus escolar y/o camioneta 校車 / 教會小巴	
		Bowling - Bolos (Grades 4-8) - 打保齡 JIB Lanes 67-19 Parsons Blvd., Flushing, NY 11365	School bus Bus escolar 校車	
	8/9	**Carnival - Feria - 嘉年華會** 142-10 Sanford Ave., Flushing, NY 11355	N/A	
	8/16	**Pizza Party - Fiesta de Pizza - 比薩派對** 142-10 Sanford Ave., Flushing, NY 11355	N/A	

PARENTAL CONSENT

By signing this form, I agree to the following terms and conditions:

1. Trip spots are reserved on a first-come, first-served basis for all registrants who have a zero balance.
2. I must make alternate arrangements for my child if my child is not going on a trip.
3. My child and I will abide by the Code of Conduct on the reverse of this form.

I, _____, as the parent or legal guardian of _____
(Print name) (Camper's name)

hereby give permission for him/her to participate in the trips and activities as indicated in the above itinerary.

SIGNATURE _____ **DATE:** _____/ _____/ 2024

(OFFICE COPY)

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KIDZCONNECT SUMMER DAY CAMP (SDC)

CODE OF CONDUCT

CODE OF CONDUCT

I understand that my child must:

A. Respect leaders (by listening attentively and following instructions).

B. Respect peers (by treating others as they would like to be treated, by participating in activities safely).

C. Respect property (by using all equipment and supplies properly and by taking good care of the facilities).

I also understand that:

1. I need to help my child be on time for Camp.
2. My child and I must follow the Camp's sign-in and sign-out procedures.
3. I must notify the Camp office when my child will be absent.
4. My child must stay in his/her class and on the Campgrounds and must secure permission from supervising Camp personnel before leaving the class or the Campgrounds.
5. For weekly trips: My child must have my consent and wear the official Summer Day Camp tee shirt.
6. If my child fails to follow the above Code of Conduct during a trip, he/she will not be permitted to attend subsequent trips unless I accompany him/her.
7. I will be notified if my child does not abide by the Code of Conduct.
8. I will be expected to work with my child to address his/her behavior issues and help rectify them.
9. If my child's behavior is consistently disruptive and/or harmful, my child's participation may be temporarily or permanently suspended at the discretion of the Summer Day Camp Director.

By my signature on the reverse of this form I declare that I have read this Code of Conduct and I agree to abide by it and to teach my child to abide by it.

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 in 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 ☐ Seizure disorder

☐ Behavioral/mental health disorder ☐ Speech, hearing, or visual impairment

☐ Congenital or acquired heart disorder ☐ Tuberculosis *(latent infection or disease)*

☐ Developmental/learning problem ☐ Hospitalization

☐ Diabetes ***(attach MAF)*** ☐ Surgery

☐ Orthopedic injury/disability ☐ Other (specify) ___

Explain all checked items above. ☐ ***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
☐	☐	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

															IgG Titers	Date
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Tdap	___/___/___	___/___/___	___/___/___				Hepatitis B	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		MMR	___/___/___	___/___/___	___/___/___				Measles	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Varicella	___/___/___	___/___/___	___/___/___				Mumps	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Mening ACWY	___/___/___	___/___/___	___/___/___				Rubella	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Hep A	___/___/___	___/___/___	___/___/___				Varicella	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Rotavirus	___/___/___	___/___/___	___/___/___				Polio 1	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Mening B	___/___/___	___/___/___	___/___/___				Polio 2	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Other ___	___/___/___	___/___/___	___/___/___				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# ___