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Beth Rivkah Day Camp
310 Crown Street, Brooklyn NY 11225
718-735-0400 Extension: 1122
www.BethRivkah.edu
Email: Daycamp@BethRivkah.Edu

Summer 5770/2010

Dear Parents,

It gives us great pleasure to inform you the Bais Rivkah Day Camp is once again ready to provide your child with another amazing summer program!

Dates: Grades 1-7 Wednesday, June 30 – Friday, August 20

Kiddie Camp (Pre 1-A & Head Start) Tuesday, July 6 – Wednesday, August 18
For Head Start day camp registration call 718-735-0400 x1156

Day Camp Fee:
Grades 1-7: $1,000 Full Summer $135.00 Per Week (T Shirt fee $10.00 per shirt not included)

Kiddie / Pre 1-A: $850 Full Summer $135.00 Per Week (T Shirt fee $10.00 per shirt not included)

Limited Scholarships are available. Deadline for scholarship application is Wednesday, May 26.

Day Camp Registration Office is located at: Bais Rivkah - 310 Crown St. –3rd Floor

Registration hours: Mondays thru Thursday from 10:00am to 3:30pm
If you are unable to come during this time call 718-735-0400 Ext: 1122 or email us for an appointment

REGISTRATION FORMS WILL BE ACCEPTED ONLY WHEN COMPLETED MEDICAL FORM SIGNED BY DOCTOR AND BY PARENT IS SUBMITTED

Please complete and return the following:

1. **Registration Contract** - one per **family**
   Include family information, the name of each child that you are registering.
   Check off which weeks each camper will be attending, and complete payment information.
   A $100 Deposit per child must be included with your Registration Contract.

2. **Day Camp Information Form**– one per **camper**

3. **Health Form** – one per **camper (must be submitted in order to register)**
   . By order of the Board of Health, only campers who have submitted a valid health form (signed by Doctor and Parent) will be allowed into camp.

4. **Full Payment** - credit cards & post dated checks are accepted.

- Completed forms and payment must be submitted no later than Wednesday, June 9.
- Deadline to submit Bais Rivkah day camp scholarship application is Wednesday, May 26
- Admission cards will be mailed only to those who have submitted all paperwork (Including medical form) and are paid in full.
- Only Children that are registered for a specific week will be admitted that week.
- We must be notified a week in advance if plans change in order for you not to be charged.

Mrs. Y. Baitelman *Mrs. Z. Gurevitz*
Day Camp Registration Office

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REGISTRATION CONTRACT FOR 2010 PRE 1-A

Last Name: ________________________________ Email Address: ____________________________________

Address: ___________________________________ Between: ____

City: _________________ State: _____ Zip: ________ Home Phone #: _________________________________

Father's Full Name: ___________________ Email Address ___________________ Cell: ___________________
Mother's Full Name: ___________________ Email Address ___________________ Cell: ___________________
Emergency Contact: ___________________ Relationship to camper: ____________ Phone #: ________________

Please complete the chart below for each child that you are registering for day camp. If not attending full summer, check off which weeks camper will be attending.

Camper's Name	Grade 09/10	Date of Birth	Full Summer	Wk of 7/6	Wk of 7/12	Wk of 7/19	Wk of 7/26	Wk of 8/2	Wk of 8/09	Wk of 8/16	FEES $135.00 per week
1											
2											

Method of Payment– Check one:
1.□ Credit Card: I ______________________herbeby authorize Beth Rivkah Day Camp to withdraw from my Credit Card the total of $_________in ____installments:

Date:______ Amount $________ Date:______Amount $________ Date:________Amount $________ Date:________Amount:_________

Date:______ Amount $________ Date:______Amount $________ Date:________Amount $________ Date:________Amount_________

*Name on Credit Card:*______________________*Card Number:*_________________________________ *Expiration Date:*__________

2.□ Check: *Total Enclosed $*______ *Checks #s and amounts:*____

3.□ Cash: *Total Enclosed $*________

Contract: I agree to the following terms and conditions:A $100 deposit per child is required upon signing this contract. I understand that day campers must be registered for each week they plan to attend. I understand that if my plans change Day Camp must be notified one week in advance of change of plans in order for me not to be charged. I give permission for the above camper(s) to participate in all camp activities as per the camp's itinerary , including swimming and those off ground. I do hereby give authority to the day camp and staff to obtain necessary emergency medical treatment for the above camper(s).

Date: _________________ Parent's Signature: ____

PARENT INFORMATION STATEMENT: BETH RIVKAH DAY CAMP, 310 CROWN STREET, BROOKLYN, NY 11225
This camp is licensed by the NYC Department of Health and Mental Hygiene and is inspected twice yearly.
The inspection reports are filed at the Bureau of Food Safety and Community Sanitation

Registration Completed: ______Date: ___________ Notes:____

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Beth Rivkah Day Camp – 5770-2010

Day Camper Information   Pre 1-A /Kiddie Camp

Please complete one form each camper:

Camper's Last Name:______________________ First Name _____________________ Full Hebrew Name:___________________

Child's Birthday ______________ Child's Hebrew birthday: ______________Mother's Full Hebrew Name: ____________________

School attended: (school year 09-10)____ Grade **completed 09-10:**__________

AM Teacher:_____________________________________ PM Teacher:____

Home Street Address: ____

Between which 2 streets____

City: _______________________________ State: ________ Zip: ____________ Home Phone #: ____________________________

Father's Name: ____ E-mail Address____

Father's Employer:_______________________ Father's work #:__________________________ Cell #:______________________

Mother's Name: _______________________________________ E-mail Address____

Mother's Employer:_____________________ Mother's work #:_______________________ Cell #:__________________________

Emergency Contact #1 Name: ____ Relationship to child: _______________________

Emergency Contact #1 phone #: _____________________________ Cell phone #: _____________________________________

Emergency Contact # 2 name: ____ Relationship to child: _______________________

Emergency Contact #2 phone #: _____________________________ Cell phone #: _____________________________________

Does your child have allergies? ______ NO B"H _____ Yes

If yes, please list: ____

What is her allergic reaction? ____

Transportation Information-Please fill in

How will your child be going home?

_____Day Camp Bus **_____Pick up**

Parent's Signature__________________________________

Please complete the chart below. If camper is not attending full summer, check off which weeks camper will be attending.

Camper's Name	Grade 09/10	Full Summer	Week of 7/6	Week of 7/12	Week of 7/19	Week of 7/26	Week of 8/2	Week of 8/9	Week of 8/16

Parent's Signature _______________________________________

Comments: ____

____

HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTERSCHOOL & YOUTH CENTERS

(This side to be filled in by parent before presentation to physician)

NAME OF PROGRAM ______________________________

______________	______________	/ /	M ❑ F ❑
CHILD'S LAST NAME	FIRST NAME	BIRTHDATE	SEX

Home Address: ______________________________ Phone: ______________

Parent or Guardian: ______________________________ Phone: ______________

Place of Employment: Father (Guardian) ______________________________ Phone: ______________

Mother (Guardian) ______________________________ Phone: ______________

In case of emergency, notify: ______________________________ Phone: ______________

If Parent, Guardian are not available in an emergency, notify:

1. ______________________________ Phone: ______________

or 2. ______________________________ Phone: ______________

Important: Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:
Yes ❑ No ❑ (If yes, state type of exposure: ______________________________)

HEALTH HISTORY: (Check box if child has had afflictions, give appropriate dates)

	Allergies
❑ Rheumatic Fever ______________	❑ Hay Fever ______________
❑ Seizures ______________	❑ Poison Ivy, etc. ______________
❑ Diabetes ______________	❑ Insect Stings ______________
❑ Asthma ______________	❑ Penicillin ______________
❑ Chicken Pox ______________	❑ Other Drugs ______________
	❑ Food ______________

Other Past Illnesses ______________________________

Operations or Serious Injuries (Dates) ______________________________

Hospitalization (Dates) ______________________________

Chronic or Recurring Illness ______________________________

Any specific activities to be encouraged? ______________________________

Conditions that require activity to be restricted? ______________________________

Permission for all program activities unless otherwise noted by Dr. ______________________________

Appliance worn (glasses, contacts, etc.) ______________________________

Medication taken ______________________________

Suggestion from Parent/Guardian ______________________________

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Day Camp and Year Round Afterschool and Youth Center Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship ______________ Signature ______________________ Date __________ Tel.# ______________

Department of Health and Mental Hygiene — The City of New York — Bureau of Food Safety and Community Sanitation

PHYSICAL EXAMINATION

(To be filled out by Physician – please note information on reverse side)

The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child in Day Camps and Afterschool and Youth Center programs.

IMMUNIZATION HISTORY – This is a record of dates of basic immunization and most recent booster doses.

DTaP, DTP, DT, Td	Date ______	Date ______	Date ______	Date ______	Date ______
Polio	Date ______	Date ______	Date ______	Date ______	Date ______
MMR	Date ______	Date ______	Date ______		
Hemophilus Influenzae type b (Hib)		Date ______	Date ______	Date ______	Date ______
Hepatitis B	Date ______	Date ______	Date ______	Date ______	
Varicella	Date ______	Date ______			
Pneumococcal Conjugate (PCV)	Date ______	Date ______	Date ______	Date ______	Date ______
Other ______	Date ______	Other ______	Date ______	Other ______	Date ______

MEDICAL EXAMINATION – To be filled out by licensed physician.

Examination is acceptable when performed no more than 12 months prior to arrival at camp.

Code: S = Satisfactory
X = Not Satisfactory (Explain)
0 = Not Examined

General Appearance ______

Genitalia ______

Height ______ Weight ______ Blood Pressure ______ Posture & Spine ______ Throat - Tonsils ______

Nose ______ Teeth ______ Abdomen ______ Hernia ______ Feet ______ Lungs ______ Skin ______

Hgb. Test (Date) ______ Urinalysis (Date) ______

Eyes ______ Vision ______ w/Glasses ______ Extremities ______ Heart ______

Ears ______ Hearing ______

Neurological Findings ______

Describe Abnormal Findings and/or Handicapping Conditions ______

______

Allergy: *(Please specify)* ______

Recommendations and restrictions while in camp:

Special Diet ______

Special Medicine (dose, route of administration, when should it be administered) ______

Is parent/guardian sending special medicine? ______

Activity Restrictions ______

Swimming ______ Diving ______

General Appraisal: ______

______

______

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in Day Camp/Year Round Afterschool and Youth Center activities, except as noted above.

______ M.D.
EXAMINING PHYSICIAN (SIGNATURE)

______
PHYSICIAN'S NAME (PLEASE PRINT)

Telephone ______ Address ______

Date of Examination ______ ______
ZIP CODE