



ת"רס"א

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

Day Camp Registration Office

Mrs. Z. Gurevitz



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

REGISTRATION CONTRACT FOR 2010 –Grade 1-7

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 6/30	Wk of 7/5	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												
3												
4												

Total

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: _____

Beth Rivkah Day Camp – 5770-2010

Day Camper Information Grade 1-7

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 completely

How will your child be going home? (Please check all that apply)

Day Camp Bus **walk alone** **walk with older sibling/neighbor**

pick up (please be here at 3:45) **other (please specify)** _____

Does your child have permission to walk home? **Yes** **No** **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 6/30	Week of 7/5	Week of 7/12	Week of 7/19	Week of 7/26	Week of 8/2	Week of 8/9	Week of 8/16

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

- | | |
|--|---|
| <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Hay Fever _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Poison Ivy, etc. _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Insect Stings _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Penicillin _____ |
| <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Other Drugs _____ |
| | <input type="checkbox"/> 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.# _____

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