Fun

2017

SUMMER CAMP

Baseball
Boys Basketball
Bowling
Football
Ice Hockey
Swimming
Tennis
Theater
Volleyball
Wrestling

friends

Niagara Falls City School District

Free

Grades 7-12

July 12–August 11

11:30 a.m.-3 p.m.

Monday—Friday

Niagara Falls H.S.

FREE! Lunch and

Bus Transportation

Niagara Falls City School District
Prep and High School ~Open to Students Entering Grades 7-12 in Sept. 2017
2017 Summer Camp Application

Child's Full Name (please print)_____Male or Female (please circle)

Address_____Zip Code (required)_____

School - _____What grade will your child be in Sept?_____

Mother/Guardian – (name)_____Home _____Work/Cell_____

Father/Guardian – (name) _____Home _____ Work/Cell _____

Emergency Contacts -Others Who May Pick Up My Child

Name	Phone		Name	Phone

Emergency Medical Information

In the event of a medical emergency, the Site Coordinator should call:	
Physician Name:	Phone:
In the event that I, or my child's physician cannot be reached in an emergency, I hereby give my permission to the physician's /hospital selected by the program to secure proper medical treatment for my child. **Parent/Guardian Signature:** **Date**:	

Please place a √ under the activity your child will participate in this summer. Your child will participate in this activity daily for the camp session.
PLEASE CHECK ONLY ONE BOX

Baseball	Basketball (Boys)	Bowling	Football	Ice Hockey

Swimming	Tennis	Theater	Volleyball	Wrestling

What size t-shirt does your child wear? Please place a √ under the correct size. ONLY (1) CHECK, PLEASE.

Small (adult)	Medium (adult)	Large (adult)	X-Large (adult)	XX-Large (adult)	XXX-Large (adult)

Parent/Guardian Memo of Understanding:

- I give consent for my child to be photographed for education material, promotional articles or any other lawful purpose.
  YES **NO**
- I give consent for my child to attend all field trips using district transportation or 'walking field trips'.
  YES **NO**

Parent/Guardian Signature: _____**Date** _____

******PLEASE RETURN TO: Niagara Falls High School, 4455 Porter Road, Summer Camp Office, Niagara Falls, NY 14305**

Questions? Call Susan Ross, Camp Director at NFHS <<NO DEADLINE FOR ENROLLMENT>> FAX 286-7964

Niagara Falls City School District

2017 SUMMER CAMP - Health History

Child's Full Name _____Sport/Activity_____

Date of Birth _____Male _____Female _____

Insurance Information -

Is the camper covered by family medical/hospitalization insurance? Yes_____ No_____

If yes, list: Carrier _____Policy# _____Group #_____

Insurance Carrier Address _____

NOTE: Campers attending schools other than Niagara Falls School District must attach a copy of their immunization record to this health history form.

Campers with religious or medical exemption from immunizations must present a written statement from parent/guardian and if possible physician.

ALL "YES" ANSWERS MUST BE EXPLAINED – Unexplained answers will delay clearance for your child.

HAS/DOES the PARTICIPANT:	**YES**	**NO**
1. Have any allergies to food, bees, etc.?		
2. Had any recent injury, illness or infectious disease?		
3. Have a chronic or recurring illness/condition?		
4. Have a bleeding disorder?		
5. Ever had surgery?		
6. Have frequent headaches?		
7. Ever had a head injury?		
8. Ever had frequent ear infections?		
9. Ever had seizures?		
10. Ever had chest pain during or after exercise?		
11. Ever passed out during or after exercise?		
12. Ever had high blood pressure?		
13. Ever been diagnosed with a heart murmur?		
14. Ever had back problems?		
15. Ever had problems with joins (i.e., knees, ankles)?		
16. Have learning disabilities?		
17. Have behavior concerns such as ADD or ADHD?		
18. Have mobility concerns?		
19. Have an orthodontic appliance?		
20. Wear glasses, contacts, protective eye wear?		
21. Have any skin problems? (i.e., rash, acne)		
22. Have asthma?		
23. Have diabetes?		
24. Had mononucleosis in the 12 months?		
25. Had problems with diarrhea/constipation?		
26. If female, begun menstruation?		
If no, has she been told about it?		
27. Ever had an eating disorder?		
28. Ever had emotional difficulties for which professional help was needed?		
29. Been taken out of GYM class this school year by his/her doctor?		
If yes, was he/she returned to GYM by the doctor?		
30. Have medications he/she takes at school?		
If yes, have your health care provider complete the attached medication form		

Please explain any "yes' answers, noting the corresponding number (use additional paper, if necessary)

Emergency Contacts -Others Who May Pick Up My Child

Name	**Phone**		**Name**	**Phone**
1.			2.	

All over the counter and prescription medications require an order from your health care provider. Please take medication form on reverse side of this form to your child's physician, if your child will require any type of medication during camp hours. Please note that any topical cream (Neosporin) is considered an over the counter medication and requires an order from the health care provider. (Sunscreen and insect repellent) only require written permission from the parent). The above information is accurate and complete to the best of my knowledge.

I hereby give permission for the medical staff of the camp to share my child's pertinent medical information with relevant camp staff.

Signature of Parent/Guardian _____Date _____

Niagara Falls City School District

2017 SUMMER CAMP

MEDICATION ADMINISTRATION: PARENT AND PRESCRIBERS AUTHORIZATION

A. To be completed by the parents or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our health care provider. THE NEW YORK STATE EDUCATION DEPARTMENT REQUIRES THAT ALL MEDICATION IS TO BE FURNISHED BY ME IN A PROPERLY LABELED ORIGINAL CONTAINER FROM THE PHARMACY AND MUST BE BROUGHT TO THE CAMP HEALTH OFFICE BY A PARENT OR GUARDIAN. It is the policy of the camp that these procedures must be followed or the camp will not be responsible for the administration of the medication. I understand that the camp nurse or other assigned person will administer the medication.

Signature (Parent or Guardian) **X** _____Date _____

Address _____Zip Code_____

Telephone – home/cell _____work _____

Parent Signature Required:
I hereby grant permission for the medical staff of the Summer Camp to obtain all medical information from my child's health care provider(s) pertaining to the medical condition on this referral and any other medical problems that may be associated with this condition. I authorize the Health Office share this information with camp personnel as needed.

X_____ _____
Signature of Parent/Guardian Date

B. To be completed by the licensed health care provider:

I request that my patient, as listed below, receive the following medication(s) during camp hours (11:30am-3pm):

Name of Camper/Patient _____ Date of Birth _____

Diagnosis _____

Name of Medicine (1) _____ (2) _____ (3) _____

Dose and Time (1) _____ (2) _____ (3) _____

Possible Side Effects and Adverse Reaction (1) _____

(2) _____ (3) _____

X_____ _____ _____
Health Care Provider Signature Date Phone

SELF-MEDICATION RELEASE FOR CAMP:

Complete this section for those students who request permission to carry their own medication.

Date _____ Child's Name _____ has been instructed in the proper use of the following medication procedures and it is requested that he/she be permitted to carry the medication on his/her person as we consider him/her responsible and self-directed. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

Health Care Provider Signature **X**_____

Parent Signature X_____