KidzConnect Summer Day Camp

法拉盛第一浸信會
142-10 Sanford Avenue, Flushing, NY 11355
Tel.: (718) 539-6822 | Fax: (929) 264-7311
sdc@fbcflushing.org | fbcflushing.org/zh-tw/camp/

二零二四年二月

親愛的家長及監護人：

我們熱烈歡迎再次及第一次參加夏令營的家庭！我們服務法拉盛社區已經超過二十五年。在 KidzConnect，我們致力於提供豐富的課程，讓小朋友在安全的環境中學習新事物，享受樂趣，我們擁有合資格的老師及小班教學。在 KidzConnect，我們致力於提供豐富的項目，讓孩子們在安全的環境中學習新事物，享受樂趣，並擁有合格的教師和小班授課。

以下是 2024 年的亮點：

- ✓ 在 5/31 或之前付清所有費用，可獲$100 優惠
- ✓ 快樂星期五：即興創作工作坊、外遊、嘉年華會！
- ✓ 二至八年級可選擇參加棋藝班。
- ✓ 六至八年級可選擇參加機械人班。

今年的主題來自詩篇 139:14a (和合本)：「我要稱謝你，因我受造，奇妙可畏；……」從不同的聖經故事中，小朋友會學習到神創造他們是有目的的，他們是珍貴的，受神所愛的。

報名詳情：

1. 填寫註冊包：
   - 註冊表(共有兩頁，請簽名)
   - 外遊/行為守則(共有兩頁，請簽名)
   - 身體檢查表 **(必須由醫護人員填寫，如沒有交回此表，小朋友不能上課。)**
2. 在 5/31 或之前邀付全部費用(現金、匯票或支票)，可獲$100 優惠。

   請郵寄或於週一至週五辦公時間親到教會報名。支票抬頭請寫 "First Baptist Church of Flushing"，並在備註上寫上 "Summer Day Camp"。需邀付所有費用才可為你的小朋友預留夏令營學位。

如有任何問題，請至電(718) 539-6822 內線 1002 (英文)、1001 (中文)或 1000 (西班牙語)與我們聯絡。請向你的親朋好友推介我們的夏令營，盼望在暑假與你們相見！

Carol Tom

Carol Tom
兒童事工傳道

FIRST BAPTIST CHURCH OF FLUSHING (FBCF)

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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

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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	

家長同意書

簽署此文件後，本人同意遵守以下條文：

1. 外遊名額以先到先得形式分配，但必須邀交全部費用才可獲得名額。
2. 如本人的孩子不參加外遊，本人將自行安排孩子活動。
3. 本人及本人的孩子將遵守此表背頁的行為守則。

本人_____是_____的家長/監護人，批准他/她參加
(家長姓名) (學生姓名)
以上的戶外活動。

簽名：_____ 日期 _____/_____/ 2024

(OFFICE COPY)

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KIDZCONNECT SUMMER DAY CAMP (SDC)
CODE OF CONDUCT – NORMAS DE CONDUCTA

行為守則

本人明白，本人的孩子必須：

A. 尊重領導人(留心聆聽及依從指示)。
B. 尊重同輩(待人如己，安全參與活動)。
C. 尊重資產(正確使用所有設備及用品，小心保護各項設施)。

本人也明白：

1. 本人需要幫助本人的小孩準時到達夏令營。
2. 本人及本人的孩子必需遵行夏令營的到達及離去程序。
3. 如本人的孩子缺席，本人必須通知夏令營的辦公室。
4. 本人的孩子必須留在教室或夏令營範圍，必須經夏令營監督人員批準才可離開教室或夏令營範圍。
5. 每週的外遊活動：本人的孩子必須獲本人授權參與，並穿著夏令營指定 T 恤。
6. 如本人的孩子在外遊時違反以上行為守則，他/她將不許參與日後的外遊，除非本人一同前往。
7. 如本人的孩子不遵守行為守則，本人將被通知。
8. 本人預期與本人的孩子一同處理他/她的行為問題及幫忙糾正。
9. 如本人的孩子的行為持續性地破壞及/或有害，本人的孩子將由夏令營主任決定暫時或永久停止參與夏令營活動。

本人聲明已細閱行為守則及同意遵守及教導本人的孩子遵守，並在背頁簽名作實。

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
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability

Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ______

☐ *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/m^2 (____ %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	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

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___ ___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

Tdap	___/___/___	___/___/___	___/___/___
MMR	___/___/___	___/___/___	___/___/___
Varicella	___/___/___	___/___/___	___/___/___
Mening ACWY	___/___/___	___/___/___	___/___/___
Hep A	___/___/___	___/___/___	___/___/___
Rotavirus	___/___/___	___/___/___	___/___/___
Mening B	___/___/___	___/___/___	___/___/___
Other	___/___/___	___/___/___	___/___/___

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
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# ☐☐☐☐☐☐☐☐☐☐