



## 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/kids

二零二五年二月

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。

以下是2025年的亮點：

- ✓ 在6/1或之前付清所有費用，可獲折扣優惠
- ✓ 快樂星期五：外遊、嘉年華會！
- ✓ 選修科：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，外語 – 一至八年級可選擇參加國語或西班牙語班

今年的主題來自馬太福音19:26 (和合本)：「……在人這是不能的，在神凡事都能。」從不同的聖經故事中，小朋友會學習到只有藉著神的恩典與對耶穌基督的信心，才能獲得救贖。即使在日常生活中，我們可能面對看似無法克服的挑戰，但神能開出一條路，讓萬事都為我們的益處而行。

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6/1或之前繳付全部費用(現金、匯票或支票)及表格，可獲折扣優惠。

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”。需繳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1005 (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！

*Myriam Cherasard*

Myriam Cherasard  
社區教育主任

# 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

2025 \_\_\_\_\_

- Registration Form     Health Form  
 GOH                       VBS

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. 2025 2025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? <input type="checkbox"/> Y <input type="checkbox"/> N Submit a copy of IEP diagnosis/assessment summary. 學生有沒有參加個人特別教育方案 IEP? <input type="checkbox"/> 有 <input type="checkbox"/> 沒有 [請提交個人特別教育方案/報告]				13. Vacation Bible School (VBS) 假期聖經學校 – August 18-22 <input type="checkbox"/> Yes/參加 <input type="checkbox"/> No/不參加			
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. ELECTIVES – LIST YOUR TOP TWO OPTIONS 選修班 – 請選擇兩項							
#1 _____ #2 _____							
(A) Arts & Crafts / 美術勞作 (Any grade)		(B) Spanish 1 / 班牙語班 (Gr. 1-8)		(C) Mandarin 1/ 國語班 (Gr. 1-8)			
(D) Chess / 棋藝班 (Gr. 2-6)		(E) Robotics / 機械人班 (Gr. 6-8)					
IF OPTION #1 IS FULL, THE STUDENT WILL BE PLACED IN OPTION #2. 如第一項選擇已滿, 學生將安排參加第二項選擇。							
STUDENTS WILL HAVE ONE (1) WEEK TO DETERMINE THEIR FINAL ELECTIVE COURSE. 家長請注意: 學生有一個星期時間作最後決定參加那一個選修班。							

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 June 1 for the discount or the first day of Camp for regular pricing.
3. Health forms must be submitted by June 25, 2025.
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 7/18/2025. 50% refund if cancelling between 7/7/2025 and 7/18/2025.
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** \_\_\_\_/\_\_\_\_/2025

### **註冊同意書**

簽署此文件後，本人同意以下條文及要求：

1. 本人批准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6/1之前繳付才可獲折扣優惠。
3. 健康檢查表必需在6/25/2025或之前交回。
4. 本人批准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：** 退款需付\$30行政費，7/18/2025之後退學，所有費用不獲退還。在7/7至7/18/2025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** \_\_\_\_/\_\_\_\_/2025

# FIRST BAPTIST CHURCH OF FLUSHING (FBCF)

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Phone: (718) 539-6822 · Fax: (718) 939-9136 · FBCFlushing.org/camp  
**KIDZCONNECT SUMMER DAY CAMP (SDC)**  
**TRIP ITINERARY & PARENT CONSENT FORM**

Camis #: 40583434  
Borough: Queens

STUDENT NAME NOMBRE DEL ESTUDIANTE 學生姓名			GRADE GRADO 年級	AGE EDAD 年齡
(v) Select Selecione 選擇	DATE FECHA 日期	TRIP DESCRIPTION DESCRIPCIÓN DEL PASEO 外遊地點	TRANSPORTATION TRANSPORTE 交通工具	
	7/11	<b>Movie - Película - 電影 (Elio)</b> AMC Bay Terrace 6 211-01 26 <sup>th</sup> Avenue, Bayside, NY 11360	School bus and/or van Bus escolar y/o camioneta 校車 / 教會小巴	
	7/18	<b>WCS - New York Aquarium</b> Surf Avenue and West 8th Street, Brooklyn, NY 11224	School bus and/or church van Bus escolar y/o camioneta 校車 / 教會小巴	
	7/25	<b>Alley Pond Environmental Ctr. (Grades Pre-K-2)</b> 142-10 Sanford Ave., Flushing, NY 11355	N/A	
		<b>New York Hall of Science (Grades 3-8)</b> 47-01 111th Street, Flushing, NY 11368	School bus and/or church van Bus escolar y/o camioneta 校車 / 教會小巴	
	8/1	<b>Laser Bounce (Grades PreK-3)</b> 80-28 Cooper Ave., Glendale, NY 11385	School bus and/or church van Bus escolar y/o camioneta 校車 / 教會小巴	
		<b>Bowling - Bolos (Grades 4-8) - 打保齡</b> JIB Lanes 67-19 Parsons Blvd., Flushing, NY 11365	School bus Bus escolar 校車	
	8/8	<b>Carnival - Feria - 嘉年華會</b> 142-10 Sanford Ave., Flushing, NY 11355	N/A	
	8/15	<b>Pizza Party - Fiesta de Pizza - 比薩派對</b> 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，但必須繳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 \_\_\_\_/\_\_\_\_/2025

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## KIDZCONNECT SUMMER DAY CAMP (SDC)

### CODE OF CONDUCT – NORMAS DE CONDUCTA

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#### 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准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 <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____
Child's Address			Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other
City/Borough	State	Zip Code	School/Center/Camp Name	District Number _____ Phone Numbers Home _____ Cell _____ Work _____
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Last Name	First Name	Email	

## TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

<b>Birth history (age 0-6 yrs)</b> <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____ <b>Allergies</b> <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____ <b>Attach MAF in in-school medications needed</b>	<b>Does the child/adolescent have a past or present medical history of the following?</b> <b>Asthma (check severity and attach MAF):</b> If persistent, check all current medication(s): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None Asthma Control Status: <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Hospitalization <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Surgery <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Other (specify) _____ Explain all checked items above. <input type="checkbox"/> Addendum attached.
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<b>PHYSICAL EXAM</b> Date of Exam: ____/____/____ Height _____ cm (____%ile) Weight _____ kg (____%ile) BMI _____ kg/m <sup>2</sup> (____%ile) Head Circumference (age ≤2 yrs) _____ cm (____%ile) Blood Pressure (age ≥3 yrs) ____/____	<b>General Appearance:</b> <input type="checkbox"/> Physical Exam WNL NI Abnl <input type="checkbox"/> Psychosocial Development <input type="checkbox"/> HEENT <input type="checkbox"/> Lymph nodes <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Language <input type="checkbox"/> Dental <input type="checkbox"/> Lungs <input type="checkbox"/> Genitourinary <input type="checkbox"/> Neurological <input type="checkbox"/> Behavioral <input type="checkbox"/> Neck <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Extremities <input type="checkbox"/> Back/spine Describe abnormalities: _____
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<b>DEVELOPMENTAL (age 0-6 yrs)</b> Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____	<b>Nutrition</b> < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____	<b>Hearing</b> Date Done ____/____/____ Results _____ < 4 years: gross hearing _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred
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Describe Suspected Delay or Concern: _____ Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>SCREENING TESTS</b> Date Done ____/____/____ Results _____ <b>Blood Lead Level (BLL)</b> (required at age 1 yr and 2 yrs and for those at risk) ____/____/____ μg/dL <b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs) ____/____/____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk Hemoglobin or Hematocrit ____/____/____ g/dL _____%	<b>Acuity (required for new entrants and children age 3-7 years)</b> ____/____/____ Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Dental</b> Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No
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CIR Number [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] Physician Confirmed History of Varicella Infection  Report only positive immunity:

<b>IMMUNIZATIONS -- DATES</b> DTP/DTaP/DT ____/____/____ Tdap ____/____/____ Td ____/____/____ MMR ____/____/____ Polio ____/____/____ Varicella ____/____/____ Hep B ____/____/____ Mening ACWY ____/____/____ Hib ____/____/____ Hep A ____/____/____ PCV ____/____/____ Rotavirus ____/____/____ Influenza ____/____/____ Mening B ____/____/____ HPV ____/____/____ Other ____/____/____	IgG Titers Date Hepatitis B ____/____/____ Measles ____/____/____ Mumps ____/____/____ Rubella ____/____/____ Varicella ____/____/____ Polio 1 ____/____/____ Polio 2 ____/____/____ Polio 3 ____/____/____
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<b>ASSESSMENT</b> <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____	<b>RECOMMENDATIONS</b> <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____
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Health Care Practitioner Signature	Date Form Completed ____/____/____	DOHMH PRACTITIONER ONLY I.D. [ ] [ ] [ ] [ ] [ ] [ ]
Health Care Practitioner Name and Degree (print)	Practitioner License No. and State	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s) Comments: _____
Facility Name	National Provider Identifier (NPI)	Date Reviewed: ____/____/____ I.D. NUMBER [ ] [ ] [ ] [ ] [ ] [ ]
Address	City State Zip	REVIEWER: _____
Telephone	Fax	Email
FORM ID# [ ] [ ] [ ] [ ] [ ] [ ]		