Thank you for enrolling in Port Day Camp!

We are very excited for this summer and are sure it's going to be a great one!

Should you need to contact us for any reason, please don't hesitate to call the Port Washington Children's Center office (516) 883-4864. Once camp begins, the Port Day Camp direct number will be provided to all families.

The Nassau County Department of Health requires that campers submit their medical information forms prior to the beginning of camp. We MUST have your forms on file in order for your child to attend camp. Please complete the enclosed emergency medical forms and age group specific form and send it **before June 1st** along with an up-to-date physical to:

Port Washington Children's Center,
232 Main Street, Suite 2,
Port Washington, NY 11050.

In order for your child to be prepared for camp each day, please have them bring a nut-free lunch, a bathing suit, a beach towel and water shoes. Please apply sunscreen before sending your child to camp. For the younger campers, bringing a full change of clothes is always a good idea. Remember all items MUST be clearly labeled with your child's full name.

Orientation for all campers will be on June 12th at 7pm in the Landmark gym. T-shirts and calendars of activities for the summer will be distributed. If you are unable to attend, please inform our office to arrange for pick up in the PWCC office after June 19th.

Remember that all campers entering Kindergarten (in September) through 6th grade will be heading to Manorhaven pool three times per week for both instructional and free swimming, all included in your basic camp fee!

We're looking forward to seeing all of you this summer for a fantastic time!

Best regards,

Veronica Casamassima
Office Manager

The Port Washington Children's Center is licensed by the Nassau County Board of Health. During the 6 weeks program the Board of Health will be inspecting our program a minimum of 2 times. All inspection reports are kept on file

THIS FORM MUST BE RETURNED BY JUNE 1ST

Please return to: **Port Day Camp**
PWCC
232 Main Street
Port Washington, NY 11050
Phone: 516-883-4864

Male ☐ **Grade Entering** _____
Female ☐
Date of Birth: _____

Last Name First Name

Street Town Zip Home Phone

Mother's Name Cell Phone Father's Name Cell Phone

Physician's Name Phone

To be Completed by Physician

Date of last well visit/physical _____

(must be within one year of child's last day of participation in the AT LAST program)

General Appearance: _____ Weight: _____
Height (without shoes): _____ BMI: _____ BMI% _____
Mouth (teeth): _____ Nasopharynx: _____ Nasal Obstruction: _____
Tonsils (diseased?): _____ Glands: Enlarged Thyroid: _____
Enlarged Lymph Nodes: _____ Chest Lungs (pathology): _____
R: _____ L: _____ Cardiovascular: Blood Pressure: _____
Abdomen: _____ Pulse Rate: _____ Heart: _____
Hernia (actual or potential) _____ Regular, irregular, tachycardia
Gastrointestinal: _____ Genitourinary:
Bones & Spine: _____ Scoliosis: _____ Defect Found: _____
Muscles: Feet: _____ Tremors: _____
Nervous System: Reflexes _____ Lab Tests: _____ Urine-sugar _____
Veins (varicose) Present: _____ Albumin

Immunization Dates (list doses)

Varicella (chicken pox)
Measles (live)
Mumps (live)
Rubella
MMR
Tine
Sabin
Rubella (live)
Tetanus
DT
DTP
Hepatitis B
HIB Vaccine
Other
Other

Serious injuries/operations or any other medical issues: _____

Daily medications: ☐ No ☐ Yes If yes, are medications taken: ☐ at home ☐ at camp (complete authorization below)

Medication Authorization

To be completed by physician if medication (prescription or over the counter) is to be administered at camp.
I request that my patient, listed above, receive the following medication:

1.
Medication _____ Diagnosis _____ Dosage _____ Method _____

Time to be given, frequency, and duration _____ Possible side effects _____

2.
Medication _____ Diagnosis _____ Dosage _____ Method _____

Time to be given, frequency, and duration _____ Possible side effects _____

his is to certify that the above-named student is in satisfactory health and may participate in all intramural and interscholastic sports and activities at the AT LAST! program vith no restrictions.

Physician's Signature ➨ _____ _____
Physician's Signature Date

THIS FORM MUST BE RETURNED BY JUNE 1ST

Please return to:

AT LAST!
PWCC
232 Main Street
Port Washington, NY
11050
Phone: 516-883-4864

Camper's Last Name | Camper's First Name

To be Completed by Parent

Medications

Does your child take medication (prescription or over the counter) daily — No ☐ Yes ☐

1.

Medication | Reason

2.

Medication | Reason

3.

Medication | Reason

4.

Medication | Reason

If yes, are medications taken: ☐ at home ☐ at program (complete authorization below)

Does your child have allergies: ☐ No ☐ Yes

If yes, please fill out the chart below even if your child has mild allergies

Health History (list dates or comments)

Chicken Pox
Measles
Rubella
Mumps
Pneumonia
Scarlet Fever
Asthma
Scoliosis
Diabetes
Epilepsy
Heart Condition
Tuberculosis
Ear Condition
Urinary Condition
Glasses
Allergy (list)

Allergy Action Plan

Allergic to	Cause of Reaction (il.e., ingestion, airborne exposure)	Symptoms of a Typical Reaction	Parents Procedure for a Typical Reaction

request that my child _____ receive the medication as prescribed on the front of this form by my physician. he medication is to be furnished by me in a properly labeled original container from the pharmacy with the prescription, expiration date, osage, Doctor's name, and patient's name listed. All medications will be dispensed under the specific direction of program staff.

Parent's Signature ➨

Parent's Signature _____ Date _____

THIS FORM MUST BE RETURNED BY JUNE 1ST

232 Main Street
Port Washington, NY 11050
Phone: 516-883-4864 Fax: 516-883-0772

Medical Emergency Authorization

THIS FORM MUST BE NOTARIZED

Date of Authorization: _____

Child's Name: _____

I give Port Day Camp/Port Washington Children's Center and the following individual(s) permission to act on my behalf in case of a medical emergency in the event that I am not available and/or not reachable.

Name of Authorized Individual	Relationship to Child	Business Phone Number	Cell Phone Number	Home Phone Number

I hereby authorize the hospital/physician where my child is brought for treatment to perform any emergency procedures or operations, to administer anesthetics, and to provide treatment to my child.

Child's Name: _____
Home Address: _____
Date of Birth: _____
Home Phone Number: _____
Mother/Guardian's Business Phone Number: _____
Mother/Guardian's Cell Phone Number: _____
Father/Guardian's Business Phone Number: _____
Father/Guardian's Cell Phone Number: _____
Child's Physician: _____
Physician's Phone Number: _____
Allergies: _____
Medication(s): _____
Child's/Family Insurance Co. Information: _____

_____ _____
Signature of Parent/Legal Guardian Date

State of New York
County of _____Sworn to before me this _____ day of _____, 20__

_____
Notary Public