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

SOUND SAILORS CAMPER PROFILE

The following information will only be used to help us better understand your child so they can have the best experiences this summer.

Name: ______________ **Nickname:** ______________ **Birth Date:** ______________

Registered school for Fall: ______________ **Grade in Fall:** ______________

Primary language spoken at home? ______________

Will your child be riding the bus to and from camp? ______________

Has your child attended day camp? ______________

If so, camp name: ______________ **When?** ______________

What are your child's favorite summer activities? ______________

Does your child make friends easily? Explain: ______________

What are your child's strengths? ______________

What are your child's weaknesses? ______________

What might frighten your child? Circle all that apply: loud noises/sirens, lightning/thunder, bugs, costumes/masks

____

How does your child transition? Circle all that apply: with cues, requires assistance, easily, with difficulty, is often resistant.. Please circle one.

Is your child a swimmer? ______ **Does your child enjoy pool time?** ______ **Is your child afraid of pool/water?** ______

With whom does your child live? ______________

Is there anything regarding home life that might impact upon your child's camp day? Please explain: ______________

____

____

Does child have his/her own room? ______________ **If shared, with whom?** ______________

Any pets? ______________

What does your child enjoy about school? Please explain: ______________

____

____

What activities does your child like to participate in? ______________________________

____

What does your family like to do together on weekends as a family? ______________________________

____

Please indicate any medications your child takes regularly (at home or school)? ______________________________

____

Any side effects? ______________ **Any hospitalizations?** ______________

If so, when and why? ______________________________

List any recurring illness (such as asthma or frequent ear aches): ______________________________

Please list allergies, if any: ______________________________

How severe? ______________________________

Are there any concerns regarding speech, hearing, coordination or behavior? Please explain: ______________

____

____

Does your child receive any services in school (such as speech, PT, OT, counseling, resource room, small class size)?

____

____

Do you have any concerns regarding your child's progress in school this past year? Explain: ______________

____

Does your child need help dressing? __________ **Toileting assistance?** ________ **Reminders?** __________

What might upset your child? ______________________________

____

How does your child self-regulate? ______________________________

____

Is there anything else that you feel would be helpful for us to know? ______________________________

____

____

Print Name: ______________________________

Signature: ______________________________

Date: ______________________________

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 & Muscles: Spine: ____ Scoliosis: Defect Found: ____
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)

Health History	
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