Lincoln Shimek Summer Camp
Registration Packet

Within this packet you'll find the Registration and Tuition Form, Emergency Medical Information Form, Physical Form and Emergency Contact Form

Important Points:

- Everyday each child will need a cold lunch, a water bottle, and sunscreen
- Camp opens at 7:30 am and closes at 5:30 pm daily
- **This year, we will be releasing the calendar at a later date**
- In order for you child or children to attend camp on their first day we must have all of the forms in this packet completed
- Registration must be done at least 1 week in advance, last minute registration is not available
- Follow us on Instagram (@lincoln_basp) or browse our website (lincoln-basp.org) for updates and more information!

2024 Summer Registration Packet

Camper's Name:_____

If you have more than one child please fill out a form for each

Staff Only:

1: ___

2: ___

3: ___

4: ___

5: ___

6: ___

7: ___

8: ___

9: ___

10: ___

Step 1: Check off the weeks your child will be attending camp

Although unlikely, field trip dates and destinations may change

- ▢ Week 1 (6/10 - 6/14) – Avatar the Last Air Bender
- ▢ Week 2 (6/17 - 6/21) – Olympics
- ▢ Week 3 (6/24 - 6/28) – Around the World
- ▢ Week 4 (7/1 - 7/5) – The Heist
- ▢ Week 5 (7/8 - 7/12) – Survivor
- ▢ Week 6 (7/15 - 7/19) – The Play/Musical
- ▢ Week 7 (7/22 - 7/26) – Film Fest
- ▢ Week 8 (7/29 - 8/2) – Science
- ▢ Week 9 (8/5 - 8/9) – Renaissance
- ▢ Week 10 (8/12 - 8/16) – Film Fest

2024 Summer Registration Packet

Step 2: Designate whether the initial payment will be Full or Half

At least half of the tuition is due by the first day your child arrives at camp, the other half due before their last week

▢ Full Tuition Initially ▢ Half Tuition Initially

Step 3: Calculate the Initial Tuition Price

If paying **full**:

$250 x _____ = _____

(# of weeks) (Total)

If paying **half**:

$125 x _____ = _____

(# of weeks) (Total)

Unfortunately, we can't accept payment that falls outside of these figures. If you opt to pay half initially, please only submit a second payment once it is the complete remaining amount

PARENTAL EMERGENCY MEDICAL CONSENT

This form must be presented upon admission for treatment

This form allows parents and guardians to authorize the provision of emergency treatment for below named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.

In the event reasonable attempts to contact have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by the doctor or dentist listed below, or if unavailable, another licensed physician or dentist.

I agree to pay all costs and fees as secured or authorized under this consent.

CHILD'S NAME:		**BIRTH DATE:**
PARENT(S)/GUARDIAN(S) WITH WHOM THE CHILD RESIDES		
1. NAME	RELATIONSHIP TO CHILD	
ADDRESS	EMPLOYER	
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME	RELATIONSHIP TO CHILD	
ADDRESS	EMPLOYER	
HOME NUMBER	CELL NUMBER	WORK NUMBER
EMERGENCY CONTACT PERSON(S)		
1. NAME	RELATIONSHIP TO CHILD	
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME	RELATIONSHIP TO CHILD	
HOME NUMBER	CELL NUMBER	WORK NUMBER
3. NAME	RELATIONSHIP TO CHILD	
HOME NUMBER	CELL NUMBER	WORK NUMBER

PERSONS AUTHORIZED TO PICK UP CHILD	**ADDRESS**	**PHONE NUMBER**
1.		
2.		
3.		

Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the center?

Name	Name

PHYSICIAN NAME	**DENTIST NAME**
PHONE NUMBER	PHONENUMBER
ADDRESS	ADDRESS
HOSPITAL PREFERENCE	
KNOWN ALLERGIES	DATEOF LASTTETANUS
PRESENT MEDICATION	
INSURANCE COMPANY	POLICY HOLDER ID

This consent will be in effect for one year beginning (date) _____

_____

SIGNATURE OF PARENT OR GUARDIAN **DATE**

_____

SIGNATURE OF PARENT OR GUARDIAN **DATE**

Iowa Child Care Resource & Referral

Consent & Release

Name of Facility: _____ Address of Facility: _____

Name of Child: _____

The following persons are allowed to pick up my child from child care in the event that I am unable to:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Anyone **NOT** permitted to pick up my child (with copy of court order, if applicable):

_____ _____ _____

_____ _____ _____

Consent is given for the items initialed below:

_____ Walking Trips

To the following: _____

_____ Motor Vehicle Trips

Type of vehicle: _____ To the following: _____

Child restraint system to be used: _____

Special needs of child during transport: _____

_____ Daily Transportation

Type of vehicle: _____ To/from the following: _____

Child restraint system to be used: _____

Special needs of child during transport: _____

_____ Swimming and/or Wading

Location: _____

_____ Other Activities (e.g. homework supervision, trips to neighborhood playgrounds, special trips)

Description: _____

_____ Photo Release

My child may be photographed while in child care. Photos may be used in newspapers or other media for the purpose of publicity or shared with other families whose children attend the child care program.

_____ Decline Photo Release

Do not photograph my child while in the child care program.

_____ _____

Signature of Parent Date

STATE OF IOWA DEPARTMENT OF
Health AND Human SERVICES

School-Age Child Health Form/Parent Statement of Health

HEALTH PROFESSIONAL COMPLETE PAGE

OR PROVIDE COPY OF WELL CHILD PHYSICAL[1]

Date of Exam: _____

Height: _____ Weight: _____

Body Mass Index: _____

☐ There are weight concerns

☐ Referral made to _____

Blood Pressure: _____

Laboratory Screening:

Blood Lead Level: Date_____ ☐ venous ☐ capillary (for child under age 6 yr.) Results _____

Hgb. / Hct: _____

Urinalysis: _____

Sensory Screening

Vision Acuity: Right eye _____ Left eye _____

Hearing: Right ear _____ Left ear _____

Tympanometry: Right ear _____ Left ear _____

Exam Results (*N = normal limits) otherwise describe*

Skin:

HEENT:

Teeth/Oral health:

Date of Dentist Exam: _____ or ☐ none to date.

Dental Referral Made Today ☐ Yes ☐ No

Heart:

Lungs:

Stomach/Abdomen:

Genitalia:

Extremities, Joints, Muscles, Spine:

Neurological:

Developmental Surveillance:

Psychosocial/Behavioral Assessment: (Depression screening starting at age 12)

Allergies:

Environmental
Medication
Food
Insects
Other

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures July 2022) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.241822402.1525543973.1674849857-346854326.1661880588

[1] Annual physical for school-age is recommended but not required

Child Name: _____

Date of Birth: _____ **Age:** _____

Immunization and TB Testing: (check as indicated)

☐ IDPH Certificate of Immunization reviewed & signed

☐ TB testing completed (only for high-risk child)

Health provider authorizes the child to receive the following while at child care or school (Include *over-the-counter* medications)

	Name	Dosage
☐ Fever/Pain reliever:		
☐ Sunscreen:		
☐ Cough medication:		
☐ Other:		

Prescribed medication should be listed with written instructions for use in child care. Medication forms available at https://hhs.iowa.gov/hcci/products

Additional Referrals made:

☐ _____

☐ _____

Health Provider Statement:

☐ The child may **fully participate** with ***NO*** health-related restrictions.

☐ The child has the following **health-related restrictions** to participation: (please specify)

☐ The child has a special needs care plan

Type of plan _____

(Please complete and give to parent for child care templates at https://hhs.iowa.gov/hcci/products)

Health Care Provider Comments:

May use stamp

Signature _____

Circle Provider Type: MD DO PA ARNP Chiropractor

Address: Telephone:

PARENT/GUARDIAN (COMPLETE THIS PAGE ANNUALLY) **Child's Name:** _____

Please use an **X** in the box ☐ for statements that apply to your child.

Date of child's last physical exam: _____
Date of last dental appointment: _____

☐ **Growth** - I am concerned about child's growth.
☐ **Appetite** - I am concerned about child's eating habits.
☐ **Rest** - My child needs to rest after school.

☐ **Illness/Surgery/Injury** - My child had a serious illness, surgery, or injury.

Please describe:

☐ **Physical Activity** - My child must restrict physical activity or needs special equipment to be active.

Please describe:

Play with friends - My child
☐ Plays well in groups with other children.
☐ Will play only with one or two other children.
☐ Prefers to play alone.
☐ Fights with other children.
☐ I am concerned about my child's play activity with other children.

Please describe:

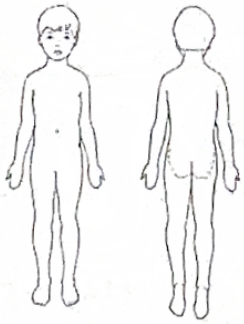
School and Learning - My child
☐ Is doing well at school.
☐ Is having difficulty in some classes.
☐ Does not want to go to school.
☐ Frequently misses or is late for school.
☐ I am concerned about how my child is doing in school.

Please describe:

☐ **Allergy** - My child has allergies (Medicine, food, dust, mold, pollen, insects, animals, etc.)
List allergies:

☐ **Body Health** - My child has problems with skin, hair, fingernails or toenails.

Describe skin marks, birthmarks, or scars.
Draw below where these marks/scars are located.



☐ Eyes/vision, glasses or contact lenses
☐ Ears/hearing, hearing assistive aides or device, earache, tubes in ears
☐ Nose problems, nosebleeds
☐ Mouth, teeth, gums, tongue, sores in mouth or on lips, breaths through mouth
☐ Breathing problems, asthma, cough
☐ Heart problems or heart murmur
☐ Stomach aches or upset stomach
☐ Trouble using toilet or accidents
☐ Hard stools, constipation, diarrhea, watery stools
☐ Bones, muscles, movement, pain when moving
☐ Mobility, child uses assistive equipment
☐ Nervous system, headaches, seizures, or nervous habits (like twitches or tics)
☐ Females – difficult monthly periods
☐ Other special needs.

Please describe:

☐ **Medication**[2] - My child takes medication.
Medication Name Time Given Reason for giving medication

☐ **Child has Emergency Medication** - Epipen, Respiratory Inhaler, Nebulizer, etc. (Please complete care/action plan) templates at https://hhs.iowa.gov/hcci/products

☐ **Special Needs Care Plan** - My child has a special need and a care plan for child care. Please discuss with your health care provider.

Parent/Guardian Signature (required) _____ Date: _____

[2] Please review the child care program's/school policies about the use of medication.