Group Preference

_____GROUP 1: June 27 to July 7 AND July 11 – July 21

_____GROUP 2: July 25 to August 4 AND August 8- August 18

YOU MUST ATTEND BOTH SESSIONS IN THE GROUP

Siblings Attending

_____

_____

_____

_____

KIDDIE KEEP WELL CAMP

2023 CIT APPLICATION

(Must be filled out completely by LEGAL PARENT/GUARDIAN only)

This is a residential (sleepaway) program

NAME OF CHILD _____ _____ ____ _____ _____/_____/_____

LAST FIRST M.I GENDER BIRTHDAY

ADDRESS _____ NJ _____

STREET CITY/TOWN STATE ZIP CODE

SCHOOL _____ ☐Parochial ☐ Private ☐ Public CURRENT GRADE: _____

PREVIOUS CAMPER _____YES _____NO If so, what year(s)? _____

LEGAL PARENT/GUARDIAN _____RELATIONSHIP TO CHILD_____

PHONE #1 _____(home/cell/work) PHONE #2 _____(home/cell/work)

EMAIL _____CURRENTLY LIVING WITH CHILD? __YES __NO

SECOND PARENT/GUARDIAN _____RELATIONSHIP TO CHILD _____

PHONE #1 _____(home/cell/work) PHONE #2 _____(home/cell/work)

AUTHORIZED TO PICK UP CHILD? ____YES _____NO CURRENTLY LIVING WITH CHILD? ____YES ____NO

Please note: Appropriate paperwork, such as custody papers, must be attached if the custodial parent requests not to release the child to the other parent.

IS THIS CHILD CURRENTLY IN FOSTER CARE? ____YES ____NO

IF YES, NAME OF FOSTER CARE AGENCY _____PHONE #_____

EMERGENCY CONTACTS *MUST BE DIFFERENT* FROM THE GUARDIAN AND PARENTS LISTED ABOVE.

I authorize the following person(s) or agency to be contacted in the event of an emergency and I cannot be reached. I also authorize the following person(s) or agency to be contacted and authorize my child to be turned over to this person(s) if for any reason my child must leave camp and I am not available. Initial_____

EMERGENCY CONTACT #1_____RELATIONSHIP TO CHILD: _____

PHONE #1 _____(home/cell/work) PHONE #2 _____(home/cell/work)

EMERGENCY CONTACT #2_____RELATIONSHIP TO CHILD: _____

PHONE #1 _____(home/cell/work) PHONE #2 _____(home/cell/work)

RELEASE OF INFORMATION AUTHORIZATION

I, _____, hereby give permission to Kiddie Keep Well Camp to secure information concerning my child, _____, in order for the Camp to determine eligibility for enrollment.

Signature _____ Date _____

FOR CAMP USE ONLY (CHECK ONCE RECEIVED)

RECEIVED _____ USDA_____ HR _____ IC _____ SESSION_____ ENT _____

HEALTH INFORMATION

Allergy (Food, Medicine, Environment, etc.)	Reaction (hives, throat swelling, shortness of breath, etc.)

Diet & Nutrition

- ☐ This camper eats a regular diet
- ☐ This camper eats a regular vegetarian diet
- ☐ This camper has special food needs (please describe) _____

Does your camper experience?

☐ Frequent Sore Throat ☐ Sleepwalking ☐ Bed Wetting

List date and explain any other diseases, disabilities, accidents or operations:

_____

_____

MEDICATIONS

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. You are required to bring any prescription medication in the original pharmacy containers with labels which show the camper's name and how the medication should be administered. Provide enough of each medication to last the entire time the camper will be at camp.

- ☐ This camper will not take any daily medications while attending camp
- ☐ This camper will take the following medications while at camp:

Medication Name	Reason for taking it	When it is given	Dosage
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time _____	
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time _____	
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time _____	
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time _____	

DOCTOR'S NAME _____ PHONE _____

DENTIST'S NAME _____ PHONE _____

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The following non-prescription medications may be stocked in the camp Health Center and are used on an *as needed basis* to manage illness and injury. Cross out those the camper should NOT be given.

Acetaminophen (Tylenol)
Aloe
Antibiotic cream
Bismuth subsalicylate (Kaopectate, Pepto-Bismol)
Calamine lotion
Dextromethorphan cough syrup (Robitussin DM)
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Generic cough drops
Guaifensin cough syrup (Robitussin)
Hydrocortisone cream
Ibuprofen (Advil, Motrin)
Lice shampoo or cream (Nix or Eliminate)
Pseudoephedrine decongestant (Sudafed)
Sore throat spray

INSURANCE INFORMATION (to be used for emergencies, special tests, X-rays, or medical consultations.)
Please attach a copy of insurance card ******Health Insurance is not a requirement to attend camp

Health Insurance Company _____ID# _____

Does the child wear glasses? Yes _____No _____Eyeglass insurance? Yes _____No _____

If yes, name of Eyeglass Insurance Company _____

My child may participate in swimming: ☐Yes ☐No

Does camper require earplugs for swimmin ɜ? ☐Yes ☐No

Is the child in Special Education? ☐Yes ☐No

If yes, please provide a copy of your child's Individual Education Plan (IEP)

- Please list the number of children in the classroom: _____
- Please list the number of teachers in the classroom: _____

Will the child be attending another camp this summer? ☐Yes ☐No

If yes, please note where and when to avoid potential conflicts_____

Has the camper:

1.	Has your child been diagnosed with learning disability?	☐Yes	☐No
2.	Has your child been diagnosed with Autistic or having Asperser's Syndrome	☐Yes	☐No
3.	Has your child been diagnosed with ADD/ADHD	☐Yes	☐No
4.	Has your child ever been diagnosed with a speech or language disability?	☐Yes	☐No
5.	During the past 12 months, seen a professional to address mental/emotional health concerns?	☐Yes	☐No
6.	Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.)	☐Yes	☐No
7.	Do you or the school have concerns about your child's behavior in school?	☐Yes	☐No
8.	Has your child ever been suspended from school?	☐Yes	☐No

Please explain "Yes" answers in the space below, noting the number of the question(s).

_____

_____

Please give a brief developmental history of your child. Include anything that you feel may help us understand your child. Our ability to help your child will be heightened if you share with us any such information.

_____

_____

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LEGAL PARENT/GUARDIAN AUTHORIZATION SECTION

PERMISSION FOR TREATMENT-DENTAL

In the event of any accident or emergency, the assigned Dental Staff or Camp Dentist has my permission to follow through on any treatment necessary including extractions as prescribed by the Camp Dentist.

SIGNATURE _____ DATE _____

PERMISSION FOR TREATMENT-MEDICAL

I the undersigned parent/guardian hereby grant permission to the medical staff or consulting physician at Kiddie Keep Well Camp, Inc. to administer medications and provide medical care for the attending camper. I also give consent for any emergency transportation deemed necessary. I understand that all attempts will be made to reach an emergency contact or me before any action is taken. If no contact is available, the decision to treat my child will be made by the camp medical advisor and camp director. I also understand that Kiddie Keep Well Camp, Inc. will treat all information pertaining to my child as confidential, however, I agree that said information may be shared with /released to appropriate personnel and/or third parties for the purpose of treating and/or supervising my child.

SIGNATURE _____ DATE _____

ASSUMPTION OF RISK

I understand that part of the camping experience involves activities and group living arrangements and interaction that may be new to my child, and that they come with certain risks and uncertainties beyond what my child may be used to dealing with at home. I am aware of these risks, and I am assuming them on behalf of my child. I realize that no environment is risk-free, so I have instructed my child on the importance of abiding by the camp's rules, and my child and I both agree that he or she is familiar with these rules and will obey them.

SIGNATURE _____ DATE _____

PHOTO RELEASE

I give Kiddie Keep Well Camp session sponsors and selected news media permission to photograph and use pictures or videos of my camper either alone or in a group for newsletters, fundraising activities, camp albums, or for use in public understanding and support of programs for children of Middlesex County. Kiddie Keep Well Camp Inc. respects the privacy of its campers and their families and does not allow unauthorized visitors to photograph the camp or campers.

SIGNATURE _____ DATE_____

RELEASE OF LIABILITY

In consideration of the opportunity afforded my child to participate on a voluntary basis in the Kiddie Keep Well program organized by Kiddie Keep Well Inc. I hereby waive any right or cause of action arising as a result of my child's participation in said camp program from which any liability may or could occur against Kiddie Keep Well Camp, or its officers, directors, agents, employees and/or volunteers, either collectively or individually.

I fully understand and agree to the terms stated above and agree that all information is complete and correct to the best of my knowledge.

LEGAL PARENT/GUARDIAN SIGNATURE: _____DATE_____

CAMP STAFF SIGNATURE: _____DATE_____

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2023 SUMMER FOOD SERVICE PROGRAM
ELIGIBILITY APPLICATION

PROGRAM NAME: Middlesex County Recreation Council Kiddie Keep Well Camp Inc.

To apply for free meals for your child, parents must carefully complete, sign, and return this application to the program office by ASAP. An application should be returned for each child enrolled regardless of household income. If you need help with this form, please call this telephone number: _____.

1 ENROLLMENT INFORMATION

Name of Child: _____ Age: _____
Last Name First Name

2 FOSTER CHILD: Complete this part and sign the application in Part 4. DO NOT complete Part 3A and 3B.

If this is a foster child, check this box ☐. Write the child's monthly personal use income. Write "0" if the child has no income $_____.

3A HOUSEHOLDS NOW GETTING SNAP OR TANF BENEFITS FOR THEIR CHILDREN – Complete this part and sign the application in Part 4 – DO NOT complete Part 3B.

SNAP Case Number: _____ TANF Case Number: _____

3B ALL OTHER HOUSEHOLDS – If you did not write a SNAP/TANF case number nor checked Foster Child, complete this part and sign the application in Part 4.

NAMES		MONTHLY INCOME				
List the Names of Everyone in Your Household	No Income	MONTHLY Gross Earnings from Work (Before Deductions)		MONTHLY Welfare, Child Support, Alimony, Unemployment Benefits	MONTHLY Payments from Pensions, Retirement, Social Security	MONTHLY Any Other Income
		Job 1.	Job 2.			
1.		$	$	$	$	$
2.		$	$	$	$	$
3.		$	$	$	$	$
4.		$	$	$	$	$
5.		$	$	$	$	$
6.		$	$	$	$	$
7.		$	$	$	$	$
8.		$	$	$	$	$
9.		$	$	$	$	$

4 SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: An adult household member must sign the application before it can be approved.

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the SNAP or TANF number is correct or that all income is reported. I understand that this information is being given for the receipt of Federal funds; that school officials may verify the information on the application and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

SIGNATURE: _____ _____
SIGNATURE OF ADULT HOUSEHOLD MEMBER *HOME ADDRESS*

_____ _____ _____
*LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER** *TOWN/CITY* *ZIP CODE*

_____ _____ _____ _____
PRINTED NAME OF ADULT SIGNING APPLICATION *DATE SIGNED* *HOME TELEPHONE* *WORK TELEPHONE*

☐ *I do not have a Social Security Number*

5 Participant's ethnic and racial identities (optional)

Mark one ethnic identity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Mark one or more racial identities:
☐ Asian
☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander

Do Not Write Below This Line - Official Use Only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12
Total Income: _____ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice a Month, ☐ Month, ☐ Year
Household size: _____
Categorical Eligibility: ____ Date Withdrawn: _____ Eligibility: Free ____ Reduced_____ Denied ____

Reason: _____
Temporary: Free_____ Reduced_____ Time Period: _____ (expires after _____days
Determining Official's Signature: _____ Date: _____
Confirming Official's Signature: _____ Date: _____
Follow-up Official's Signature: _____ Date: _____

SFSP/Letter to Parent-Eligibility Application 2022-2023

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Leadership Development Questions
Please briefly answer the following questions?

1. What do you hope to gain/ learn from being a member of the leadership development program?

2. What is an accomplishment that you are most proud of?

3. Who is someone you consider to be a positive leader and why?

4. What are three goals you have for the future?

5. What do you anticipate being the most challenging part about the program?