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# CAMP RUACH HACHAIM

CAMP FOR BOYS WITH SPECIAL NEEDS FROM ALL OVER THE WORLD.


**CITY ADDRESS:**

266 Penn Street • Brooklyn, NY 11211

Tel: 718.963.0090

E-mail: cmpruachhachaim@gmail.com

Visit us at: www.campruachhachaim.org


ATTACH PHOTO HERE (MANDATORY)

## CAMPER APPLICATION - SUMMER 2016

**BEGINS:** WED. JULY 6, '16 **ENDS:** MON. AUGUST 29, '16

**CHANGE OF TRIPS:** AUGUST 2, **VISITING DAYS:** JULY 17 AND AUGUST 21

**CAMP FEE: $7,250 / Whole Summer - $4,800 / Half Summer**

☐ Whole Summer ☐ First Half ☐ Second Half ☐ 2 Weeks

Last Name: _____ First Name: _____ Nickname (if applicable) _____

Home Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: ____ /____ /____

Home phone: ( ____ ) _____ Summer phone: ( ____ ) _____

Fax: ( ____ ) _____ Current Yeshiva: _____ Grade: _____

Medical Insurance: _____ Policy # _____ Camper's e-mail: _____

| FATHER | MOTHER |
|---|---|
| Name: _____ | _____ |
| Occupation: _____ | _____ |
| Work Phone: _____ | _____ |
| E-mail: _____ | _____ |
| Cell Phone: _____ | _____ |

### REFERENCES

Please list two references and include a rebbe or principal

Name: _____

Phone (Day & Eve): _____

Position: _____

Name: _____

Phone (Day & Eve): _____

Position: _____

Emergency contact (If we cannot reach you)

_____

NAME PHONE RELATIONSHIP TO CAMPER

_____

NAME PHONE RELATIONSHIP TO CAMPER

### CONDITIONS OF ENROLLMENT

I agree to adhere to all rules and regulations which govern: 1- the CRH registration process 2- my child's stay at CRH and 3- payment schedules and terms.

It is expressly understood and agreed that CRH reserves the unrestricted right to dismiss, without a refund, any camper whose conduct or influence is deemed detrimental to the CRH operation or inimical to the best interest of CRH.

No reduction or refund can be made for late arrival, early departure or dismissal.

The cost for the replacement of any items damaged due to misuse, wilful destruction or loss by the participant, will be charged to the camper's canteen account or billed directly to the parents.

I acknowledge that, although CRH operates with the highest safety standards and has taken measures to minimize the risk of injury to CRH participants, CRH cannot insure nor guarantee that the participants, equipment, premises, and/or activities will be free of hazards, accidents or injuries. I recognize these inherent risks and understand that I have assumed these risks by enrolling my child. Furthermore, I have instructed my child in the importance of knowing and abiding by CRH rules, regulations and procedures for the safety of CRH participants.

I agree to abide by all CRH rules and procedures regarding medical care as detailed in the Terms of Agreement.

CRH is authorized to use analog and/or digital photographic, audio and/or video reproductions of my child electronically and in literature for promotional purposes.

Acceptance as a camper is subject to the CRH checking all references and review of the confidential Camper Profile and Medical/Health Form, even for a returning camper.

CRH will not be held responsible for clothing or personal effects lost or damaged by fire, theft, or laundry. Once the CRH season ends, all personal items will be disposed of by the janitorial staff.

I herby give permission for my child to go on all off-campus trips and participate in all activities.

Medical Authorization: In the event of accident or illness I authorize CRH to institute and obtain medical care for my son.

I agree to abide by the above and all terms of CRH's financial "Terms of Agreement".

Disclaimer: CRH does not assume responsibility in the event of any occurrences beyond its control which may cause for a delay and/or postponement in camp's opening and/or closing dates.

X _____ _____ _____

PARENT'S SIGNATURE PRINT FULL NAME DATE

**PLEASE FILL OUT INFORMATION ON BOTH SIDES AND SEND BACK WITH DEPOSIT.**

## BUNK REQUESTS

We cannot guarantee you will bunk together but we will do our utmost to honor all requests.

1st choice: _____ 2nd choice: _____

To receive your complimentary T-shirt, please indicate correct size

☐ Adult Small ☐ Adult Medium ☐ Adult Large ☐ Adult X-Large

## CAMPER INFORMATION

Is camper currently under the care of a physician or psychologist? please specify_____

_____

Are there any unusual circumstances of which we should be aware? _____

_____

If necessary, please attach an additional sheet.

Is your child being referred to CRH by an agency? ___Yes ____No

If yes please fill out the following:

Name of Referring Agency_____ Case Number (if applicable)_____

Contact Person_____ Tel._____ Ext._____ Fax _____

When returning your application, please also submit a letter from the referring agency stating how much they will reimburse CRH.

Will you require transportation to and/or from camp:

To camp: ☐ Yes ☐ No _____ From camp: ☐ Yes ☐ No

USDA ELIGIBLE _____

I hereby enroll my child for the coming season of 2015. In case of emergency, I give permission to the physician selected by the Camp Director to hospitalize and/or secure proper treatment for my son. I hereby authorize Camp Ruach Hachaim to take my child off camp grounds to go on trips as part of the camping program.

**Parent's Signature** _____ **Date** ____ /____ /____

**Parent's comment or suggestion:**

_____

_____

**FOR OFFICE USE - CAMP PAYMENTS**

**DATE** ____ /____ /____ **AMOUNT $** _____ **DATE** ____ /____ /____ **AMOUNT $** _____

**DATE** ____ /____ /____ **AMOUNT $** _____ **DATE** ____ /____ /____ **AMOUNT $** _____

# MEDICAL FORM

## THIS SIDE TO BE COMPLETED BY PARENT/GUARDIAN

Name _____ Date of Birth ____/____/____ Age _____
Address _____ City _____ State _____ Zip _____
Parent/Guardian: _____ Home Phone# _____
Business Phone# _____ Cell Phone# _____
Summer Phone # _____ E-mail _____
Emergency Contact & Phone _____ Relationship _____

Check if your child has or has had any of the following conditions:

- ☐ Clotting Disorder
- ☐ Food Allergy*
- ☐ Heart Condition
- ☐ Epilepsy
- ☐ Other*
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Behavioral Issues
- ☐ Allergy to Medication
- ☐ Seizures
- ☐ Bee Sting Allergy
- ☐ Chicken Pox (date_____)
- ☐ Asthma

Please Specify:

_____

Please indicate history of above and medication and/or treatment to be continued in camp

_____

_____

**Important**: Please make sure that there is an adequate supply of any medication that your son is taking for the duration of his camp stay.

Please tape a copy of your insurance card in the designated box below:

| Please make sure all numbers are clearly visible on copy<br><br>FRONT OF CARD | BACK OF CARD |
|---|---|

## Meningococcal Meningitis Vaccination Response Form

New York State Public Health Law requires the operator of an overnight camp to maintain a completed response form from every camper who attends for seven or more nights.

CHECK ONE BOX AND SIGN BELOW

☐ My child has had the meningococcal meningitis immunization (Menomune TM) within the past 10 years.
Date received: _____

I have read, or have had explained to me, the information regarding meningococcal meningitis disease.

☐ I understand the risks of not receiving the vaccine. I have decided that my child will not obtain immunization against meningococcal meningitis disease.

Sign
Parent's Signature _____ Date _____
Witness _____ Date _____

**********

I, the undersigned, parents(s) of _____, a minor, do hereby authorize Camp R. Hachaim as our agent(s) to consent to any diagnostic procedure or medical care which is deemed advisable by, and is rendered under the general or special supervision of any licensed physician and surgeon at a Hospital or Doctor's office. It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital/Private Doctors which the physician exercises his/her best judgment may deem advisable. The authorization shall remain in effect, unless revoked in writing and delivered to said agent(s).

Sign
**Parents Signature** _____ **Date** _____

## THIS SIDE TO BE COMPLETED BY EXAMINING PHYSICIAN

I have examined the above named applicant on: _____

Blood Pressure: _____ Heart Rate: _____ Height: _____ Weight _____

Patient has the following allergies: _____

Medication and or treatment to be continued at camp: _____
_____Does condition preclude from participating in an active camp program? _____
_____Patient was found to be in good health with the followinig exceptions:
_____

| Vaccines | Dates of Immunization | Dates of Booster |
|---|---|---|
| DPT – DT – Tetanus | | |
| MMR | | |
| Polio | | |
| Hepatitis A | | |
| Hepatitis B | | |
| HIB | | |
| Varicella | | |

The following medications are acceptable for administration as per dosage as labeled except as note below:

| Name of Medication | Exception | Name of Medication | Exception |
|---|---|---|---|
| Acetaminophen (Tylenol) | | Milk of Magnesia | |
| Antibiotic Ointment | | Pepto Bismol | |
| Anti-Diarrheal | | Senna – Lax | |
| Anti-Fungal Cream | | Sudafed | |
| Benadryl | | Tums | |
| Claritin | | Tylenol Cold | |
| Cortisone Ointment | | Tylenol Sinus | |
| Cough Syrup – DM | | Vasocon-A | |
| Dramamine | | Visine | |
| Gas-X | | Other: | |
| Ibuprofen (Advil) | | Other: | |

Doctor's Signature

Physician's Signature: _____ Date: _____

Physician's Name: _____
Address: _____
Telephone #: _____ Fax: _____ e-mail: _____