



Director: Esther Lee
33-55 Bell Blvd. Bayside NY 11361
(718) 357-3355 (church office), (718) 450-2082 (director)
Email: nyskcm@gmail.com

※ Must fill out one application per child (두명 이상의 자녀분이 계실 경우 각자 등록 신청서를 따로 작성하셔야 합니다)

Name [이름]	[한글] [English]					
DOB (생년월일): / / (mm/dd/yy)			() Grade in September 2024 금년 9 월에 올라갈 학년		Sex (성별) : 남 M 여 F	
Address [집주소]						
Parent/Guardian Information [부모성명]	Mother/Guardian (어머니/보호자):			Father/Guardian (아버지/보호자):		
	Home # (집)			Home # (집)		
	Work # (직장):			Work # (직장):		
	Cell # (핸드폰):			Cell # (핸드폰):		
	E-mail:			E-mail:		
Emergency Contact [긴급 연락처]	Name (성명)			Contact # (전화번호):		Relationship (관계):
	Name (성명)			Contact # (전화번호):		Relationship (관계):
Siblings attending this summer school [여름학교 출석 형제]	Name (성명)			Grade (학년):		DOB (생년월일):
	Name (성명)			Grade (학년):		DOB (생년월일):
Church Attending [출석교회]	1) ☐ Church (교회): 2) ☐ Catholic (카톨릭): 3) ☐ Not attending any church (교회 안 다님)					
Registration [등록]	T-Shirt Size Check One: ☐ Small (6-8) ☐ Medium (10-12) ☐ Large (14-16) ☐ Other: _____					
	Please make checks payable to: Shin Kwang Church of New York					
	There are no refunds on tuition					

PARENTAL/GUARDIAN RELEASE AND PERMISSION

I, _____, as the legal guardian of above named child, release, absolve and hold harmless Shin Kwang Church, its teachers, volunteers, staff, and directors in case of any incident that may occur in relation to Shin Kwang Christian Summer Camp. I give my child permission to attend Shin Kwang Church Summer Camp and participate in all activities and will comply with the mask mandates. I hereby consent to the participation in interviews, the use of quotes, and the taking of photographs, movies or videos of the student registered above. I also grant the right to edit, use, and reuse said products for non-profit purposes including use in print, on the internet, and all other forms of media. I understand, according to Shin Kwang Christian Summer Camp refund policy, that there are absolutely **NO REFUNDS** on camp registration, tuition and/or fees.

Liabilities Release Confirmation: The staff of this summer camp will do their best to assure all appropriate and reasonable safety measures with respect to your child's attendance, travel, and other activities (such as day trips) associated with the summer camp. However, the School will not assume any liability incurred as a result of any attendance, travel, and other activities related with the School. I read this condition and I waive my rights to take any legal action against this camp and/or its staff.

I have read this release and permission and approve of its terms.

Parent/Guardian Signature (보호자 서명): _____

Date (날짜): _____

For Office Use:			
Date Received	Payment	Waiver Form	Medical Record
/ / 2024	/ / 2024	/ / 2024	/ / 2024



Shin Kwang Christian Summer Camp

Director: Esther Lee
33-55 Bell Blvd. Bayside NY 11361
(718) 357-3355 (church office), (718) 450-2082 (director)
Email: nyskcm@gmail.com

***ALL STUDENTS MUST HAVE RECENT NYC HEALTH FORM COMPLETED BY
PHYSICIAN/ DOCTOR IN ADDITION TO THIS FORM***

- ☐ SHIN KWANG CHRISTIAN CHURCH SUMMER CAMP 20__
- ☐ SUPPLEMENTAL MEDICAL FORM

Child's Name: _____ Grade: _____

Date of Birth : _____ Age: _____

Phone: _____

I, _____ (print guardian's name), give permission to
Shin Kwang Church of New York Christian Summer Camp to administer the following
first aid items in case of emergencies and daily temperature checks before entering the
camp to _____ (print child's name).

X _____
Guardian's Signature Date

- ☐ Please **check** all that may be administered to your child:
귀하의 자녀에게 투여될 수 있는 사항을 모두 표시해 주십시오:

- | | |
|--|---|
| ☐ Digital Thermometer 디지털 온도계 | ☐ Pepto-Bismol 펩토비스몰 |
| ☐ Alcohol Swabs 알코올 면봉 | ☐ Cough Syrup 기침시럽 |
| ☐ Anti-Itch Ointment 가려움증 방지 연고 | ☐ Bandages 붕대, 반창고 |
| ☐ Gauze Pads 거즈 패드 | ☐ Ice Bag 얼음주머니 |
| ☐ Antibiotic Ointment 항생제 연고 | ☐ Tylenol 타이레놀, 해열제 |
| ☐ Skin Lotion 스킨로션 | ☐ Ibuprofen 아이브프로펜 |
| ☐ Hydrogen Peroxide 과산화수소 | |

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please
Print Clearly
Press Hard

STUDENT ID NUMBER
OSIS

--	--	--	--	--	--	--	--	--	--

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex ☐ Female ☐ Male	Date of Birth (Month/Day/Year) ____/____/____
Child's Address		Hispanic/Latino? ☐ Yes ☐ No	Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other	
City/Borough	State	Zip Code	School/Center/Camp Name	District Number
Health insurance (including Medicaid)? ☐ Yes ☐ No		Parent/Guardian Last Name		First Name
		Foster Parent		Phone Numbers Home _____ Cell _____ Work _____

TO BE COMPLETED BY HEALTH CARE PROVIDER If "yes" to any item, please explain (attach addendum, if needed)

Birth history (age 0-6 yrs) ☐ Uncomplicated ☐ Premature: _____ weeks gestation ☐ Complicated by _____ Allergies ☐ None ☐ Epi pen prescribed ☐ Drugs (list) _____ ☐ Foods (list) _____ ☐ Other (list) _____	Does the child/adolescent have a past or present medical history of the following? ☐ Asthma (check severity and attach MAF/Asthma Action Plan): ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent If persistent, check all current medication(s): ☐ Inhaled corticosteroid ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None ☐ Attention Deficit Hyperactivity Disorder ☐ Orthopedic injury/disability ☐ Chronic or recurrent otitis media ☐ Seizure disorder ☐ Congenital or acquired heart disorder ☐ Speech, hearing, or visual impairment ☐ Developmental/learning problem ☐ Tuberculosis (latent infection or disease) ☐ Diabetes (attach MAF) ☐ Other (specify) _____	Medications (attach MAF if in-school medication needed) ☐ None ☐ Yes (list below) _____ Dietary Restrictions ☐ None ☐ Yes (list below) _____
--	--	---

Explain all checked items above or on addendum

PHYSICAL EXAMINATION Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m ² (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____	General Appearance: <table border="0"> <tr> <td>NI Abnl</td> <td>NI Abnl</td> <td>NI Abnl</td> <td>NI Abnl</td> <td>NI Abnl</td> </tr> <tr> <td>☐ HEENT</td> <td>☐ Lymph nodes</td> <td>☐ Abdomen</td> <td>☐ Skin</td> <td>☐ Psychosocial Development</td> </tr> <tr> <td>☐ Dental</td> <td>☐ Lungs</td> <td>☐ Genitourinary</td> <td>☐ Neurological</td> <td>☐ Language</td> </tr> <tr> <td>☐ Neck</td> <td>☐ Cardiovascular</td> <td>☐ Extremities</td> <td>☐ Back/spine</td> <td>☐ Behavioral</td> </tr> </table> Describe abnormalities: _____	NI Abnl	NI Abnl	NI Abnl	NI Abnl	NI Abnl	☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Skin	☐ Psychosocial Development	☐ Dental	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Language	☐ Neck	☐ Cardiovascular	☐ Extremities	☐ Back/spine	☐ Behavioral
NI Abnl	NI Abnl	NI Abnl	NI Abnl	NI Abnl																	
☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Skin	☐ Psychosocial Development																	
☐ Dental	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Language																	
☐ Neck	☐ Cardiovascular	☐ Extremities	☐ Back/spine	☐ Behavioral																	

DEVELOPMENTAL (age 0-6 yrs) ☐ Within normal limits If delay suspected, specify below ☐ Cognitive (e.g., play skills) _____ ☐ Communication/Language _____ ☐ Social/Emotional _____ ☐ Adaptive/Self-Help _____ ☐ Motor _____	SCREENING TESTS <table border="1"> <thead> <tr> <th></th> <th>Date Done</th> <th>Results</th> </tr> </thead> <tbody> <tr> <td>Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)</td> <td>____/____/____</td> <td>____ μg/dL</td> </tr> <tr> <td>Lead Risk Assessment (annually, age 6 mo-6 yrs)</td> <td>____/____/____</td> <td>☐ At risk (do BLL) ☐ Not at risk</td> </tr> <tr> <td>Hearing ☐ Pure tone audiometry ☐ OAE</td> <td>____/____/____</td> <td>☐ Normal ☐ Abnormal</td> </tr> <tr> <td colspan="3">Head Start Only</td> </tr> <tr> <td>Hemoglobin or Hematocrit (age 9-12 mo)</td> <td>____/____/____</td> <td>____ g/dL ____ %</td> </tr> </tbody> </table>		Date Done	Results	Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	____/____/____	____ μg/dL	Lead Risk Assessment (annually, age 6 mo-6 yrs)	____/____/____	☐ At risk (do BLL) ☐ Not at risk	Hearing ☐ Pure tone audiometry ☐ OAE	____/____/____	☐ Normal ☐ Abnormal	Head Start Only			Hemoglobin or Hematocrit (age 9-12 mo)	____/____/____	____ g/dL ____ %	Tuberculosis Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school <table border="1"> <thead> <tr> <th></th> <th>Date Done</th> <th>Results</th> </tr> </thead> <tbody> <tr> <td>PPD/Mantoux placed</td> <td>____/____/____</td> <td>Induration _____ mm</td> </tr> <tr> <td>PPD/Mantoux read</td> <td>____/____/____</td> <td>☐ Neg ☐ Pos</td> </tr> <tr> <td>Interferon Test</td> <td>____/____/____</td> <td>☐ Neg ☐ Pos</td> </tr> <tr> <td>Chest x-ray (if PPD or Interferon positive)</td> <td>____/____/____</td> <td>☐ NI ☐ Not Indicated ☐ Abnl</td> </tr> <tr> <td>Vision (required for new school entrants and children age 4-7 yrs)</td> <td>____/____/____ ☐ with glasses</td> <td>Acuity Right ____/____ Left ____/____ Strabismus ☐ No ☐ Yes</td> </tr> </tbody> </table>		Date Done	Results	PPD/Mantoux placed	____/____/____	Induration _____ mm	PPD/Mantoux read	____/____/____	☐ Neg ☐ Pos	Interferon Test	____/____/____	☐ Neg ☐ Pos	Chest x-ray (if PPD or Interferon positive)	____/____/____	☐ NI ☐ Not Indicated ☐ Abnl	Vision (required for new school entrants and children age 4-7 yrs)	____/____/____ ☐ with glasses	Acuity Right ____/____ Left ____/____ Strabismus ☐ No ☐ Yes
	Date Done	Results																																				
Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	____/____/____	____ μg/dL																																				
Lead Risk Assessment (annually, age 6 mo-6 yrs)	____/____/____	☐ At risk (do BLL) ☐ Not at risk																																				
Hearing ☐ Pure tone audiometry ☐ OAE	____/____/____	☐ Normal ☐ Abnormal																																				
Head Start Only																																						
Hemoglobin or Hematocrit (age 9-12 mo)	____/____/____	____ g/dL ____ %																																				
	Date Done	Results																																				
PPD/Mantoux placed	____/____/____	Induration _____ mm																																				
PPD/Mantoux read	____/____/____	☐ Neg ☐ Pos																																				
Interferon Test	____/____/____	☐ Neg ☐ Pos																																				
Chest x-ray (if PPD or Interferon positive)	____/____/____	☐ NI ☐ Not Indicated ☐ Abnl																																				
Vision (required for new school entrants and children age 4-7 yrs)	____/____/____ ☐ with glasses	Acuity Right ____/____ Left ____/____ Strabismus ☐ No ☐ Yes																																				

IMMUNIZATIONS - DATES CIR Number of Child _____ Hep B ____/____/____ Rotavirus ____/____/____ DTP/DTaP/DT ____/____/____ Hib ____/____/____ PCV ____/____/____ Polio ____/____/____	Influenza ____/____/____ MMR ____/____/____ Varicella ____/____/____ Td ____/____/____ Tdap ____/____/____ Hep A ____/____/____ Meningococcal ____/____/____ HPV ____/____/____ Other, specify: ____/____/____; ____/____/____
--	---

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet ☐ Restrictions (specify) _____ Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ____/____/____ Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision ☐ Other _____	ASSESSMENT ☐ Well Child (V20.2) ☐ Diagnoses/Problems (list) _____ ICD-9 Code _____ _____ _____
--	--

Health Care Provider Signature	Date ____/____/____	DOHMH PROVIDER ONLY I.D. _____
Health Care Provider Name and Degree (print)	Provider License No. and State	TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)
Facility Name	National Provider Identifier (NPI)	Comments
Address	City	Date Reviewed: ____/____/____
Telephone (____) _____	Fax (____) _____	I.D. NUMBER ____/____/____
		REVIEWER: _____