Register for Your Summer at Westmont

Full Name of Child (one child per registration form) _____ Date of Birth _____

Address: _____

Current Westmont Student: ☐ Yes ☐ No

T-Shirt size: S / M

Registration, payment, and all forms must be submitted before securing your child's spot in camp.
There will be no refunds after June 1st.

Summer Academy

Program hours: 9:00 am - 12:00 pm

Prices are per week, but Reading, Writing, and Math Camps are designed as 2-week programs.

STEM	June 26 - 30	$290 _____
Reading Academy	July 3-14* (both weeks)	$525 _____
	July 3 - 7 *	$235 _____
	July 10 - 14	$290 _____
STEM	July 17 - 21	$290 _____
Writing Academy	July 24 - August 4 (both weeks)	$550 _____
	July 24 - 28	$290 _____
	July 31 - August 4	$290 _____
Math Academy	August 7 - 18 (both weeks)	$550 _____
	August 7 - 11	$290 _____
	August 14 - 18	$290 _____

*No class July 4th

Summer Camp

Program hours: 9:00 am - 12:00 pm

Paint, Print, Paste	June 26 - 30	$275 ____
Spanish Fiesta	July 3 - 7 *	$220 ____
Art in Nature	July 10 - 14	$275 ____
Literature Adv.	July 17 - 21	$275 ____
World is a Stage	July 24 - 28	$275 ____
3-2-1 Blast Off	July 31 - August 4	$275 ____
Farm to Table	August 7 - 11	$275 ____
Cooking up Fun	August 14 - 18	$275 ____

*No class July 4th

For Office Use Only:

Date Rec'd: _____ Time Rec'd: _____

Check #: _____ Enrolled: _____

Summer Fun for Toddlers

Program hours: 9:00-11:00 am—T/W/TH

Camp Little STEPS

Session 1:	**FULL**	July 5-7* (W-F)	$200_____
Session 2:	**FULL**	July 11-13	$200_____
Session 3:	**FULL**	July 18-20	$200_____
Session 4:	**FULL**	July 25-27	$200_____
Session 5:		July 14, 21, 28	$200_____
Session 6:		August 8-10	$200_____

*No class July 4th

Extended Day Program

Before Camp 8:00 am - 9:00 am

6/26 - 6/30	$50 _____	7/24 - 7/28	$50 ____
*7/03- 7/07	$40 _____	7/31 - 8/04	$50 ____
7/10 - 7/14	$50 _____	8/07 - 8/11	$50 ____
7/17 - 7/21	$50 _____	8/14 - 8/18	$50 ____

Afternoon Camp 12:00 pm - 4:00 pm

6/26 - 6/30	$200 _____	7/24 - 7/28	$200 ____
*7/03- 7/07	$160 _____	7/31 - 8/04	$200 ____
7/10 - 7/14	$200 _____	8/07 - 8/11	$200 ____
7/17 - 7/21	$200 _____	8/14 - 8/18	$200 ____

*No class July 4th

The Afternoon Extended Day Program is also available for hourly drop-in. The as-needed rate is $12.50/hour (billed per hour). Discounted weekly rates listed above are for prepaid registrants.

Summer Academy -	**Total: $_____**
Summer Camp -	**Total: $_____**
Little Steps -	**Total: $_____**
Extended Day -	**Total: $_____**
Grand Total -	**$_____**

2017 Summer Policies

- All completed registration forms and full payment must be submitted upon registering for camp.
- **NO REFUNDS** are issued after June 1st.
- Forms required by the State must be on file in order for a child to attend the camp session. These include:

  _____ Child Information Sheet

  _____ Immunization Confirmation (for current Westmont students only)

  _____ Universal Health Care Form and immunization records signed by your pediatrician (for new students to Westmont)

I have read the above policies and agree to abide by them.

_____	_____	_____
Child's Name	Parent/Guardian Signature	Date

For Currently Enrolled Westmont Students Only

This information is required by State Law and MUST be signed and submitted before child can attend.

Immunization Confirmation

According to Chapter 14 of the State Sanitary Code (NJAC 8:57-4.1 to 8:57-4.17, "Immunization of Pupils in Schools") the State of New Jersey requires all children (no matter the age) entering Westmont School summer camps/workshops to be age appropriately immunized.

Referring to Table 1 (Required Immunizations by Age for NJ Child Care Centers) all children entering summer camps/workshops at Westmont are required to have:

Up to age 4:

- 4 doses DTaP
- 3 doses IPV
- 1 dose Hib (one dose given after 1st birthday)
- 1 dose MMR (administered after the 1st birthday)
- 1 dose Varivax or Varicella (administered after the 1st birthday)
- 1 dose Pneumonia (administered after the 1st birthday)

Entering Kindergarten:

- 4 doses DTaP (one dose must be given on/or after 4th birthday)
- 3 doses IPV (one dose must be given on/or after the 4th birthday)
- 2 doses MMR (administered after the 1st birthday)
- 1 dose Varivax or Varicella (administered after the 1st birthday)
- 3 doses HEP B

MY CHILD IS APPROPRIATELY IMMUNIZED ACCORDING TO THE GUIDELINES LISTED ABOVE.

Parent/Guardian Signature:_____ Date:_____

Proof of current immunization records must be on file at Westmont.

The Westmont Montessori School—2017 Summer Program
Child Information Sheet

FORM MUST BE FILLED OUT, SIGNED, AND RETURNED TO SCHOOL BEFORE YOUR CHILD CAN BE ENROLLED IN SUMMER CAMP.

CHILD'S NAME:_____ **DOB:**_____ **HOME PHONE #** _____

Parent/Guardian's Name:_____ Email:_____ # during camp_____

Parent/Guardian's Name:_____ Email:_____ # during camp_____

EMERGENCY CONTACT—(Other than Parent/Guardian)

Name:_____ Relationship:_____ Home Phone #_____ # during camp_____

TRANSPORTATION AUTHORIZATION—Please indicate those persons who are authorized to transport your child to and from camp.

Name:_____ Relationship:_____ Phone # During Camp: _____

Name:_____ Relationship:_____ Phone # During Camp: _____

CHILD'S HISTORY

Pertinent Medical History of Chronic Illness and Allergies: _____

Current medication to be administered (if applicable)*:_____

(*Medication/Dose/Instructions)

EPI-PEN? ☐ Yes (If yes, a signed action plan from a Physician with epi-pen is required.)

ASTHMATIC? ☐ Yes (If inhaler needed, a signed action plan from a Physician with inhaler is required.)

AUTHORIZATION FOR EMERGENCY TREATMENT - Physician Name:_____ Phone #:_____

Insurance Provider:_____ Policy #:_____ Name on Policy:_____ DOB:_____

I, the undersigned, do hereby authorize The Westmont Montessori School, to whom we have entrusted the care of the above minor, consent to any necessary emergency medical or surgical treatment, anesthesia, or any required diagnostics tests, in the event that I cannot be contacted. **Do not hesitate to administer medication and/or call 911 when parents/guardian or emergency contacts, cannot be reached.**

Parent/Guardian Signature: _____ **Date:** _____

THIS FORM & IMMUNIZATIONS REQUIRED FOR NEW STUDENTS ONLY

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860.
   - The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.