ST. MATTHEW'S CDC
856-629-4614
DR. RAYMOND M. GORDON, SR. ~PRESIDENT

CAMP KOINONIA

Where Kids Want To Be

Registration Packet

June 20- August 12, 2016

245 GLASSBORO RD., WILLIAMSTOWN, NJ 08094

Camp Koinonia

Our mission is to provide a curriculum driven program for boys and girls where they will be nurtured and developed to be righteous, responsible, respectful, well rounded, mature Christian young men and women who will then become a resource for our Lord and Savior Jesus Christ.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY!

If you have any questions, please call: 856.629.4614 or E-mail koinonia@stmatthewsbc.com

CAMP DATES

Monday, June 20, 2016 through Friday, August 12, 2016

TIME

Camp Hours: 9:00A – 4:00P

It is vital to our daily operations that campers arrive before 9:00a so that they have ample time to get signed in and settled down before the day's activities begin. In the rare event that the camper will arrive late, it is imperative that you call the camp so that we know that your child will be late and what time they will arrive. Please understand that on days when trip departure is in the morning, we cannot wait. We have a schedule to keep and would appreciate your cooperation. Also, if you need to change the number of weeks attending or add additional week(s), please do so in writing within 2 weeks prior to that week.

Likewise, if your child will be absent on a day or week that they were scheduled to attend; please give us a call so that we can alert their counselors to their absence. Thank you very much.

EXTENDED HOURS: 7:00A – 9:00A; 4:00P – 6:00P

Extended hours are provided as a service for those individuals with a need to drop off and/or pick up their children outside of the regular camp hours. It is a service that we provide in keeping with our mission to "meet the needs" of the people. While it is our pleasure to be able to serve you in this capacity, please be consistent with your drop off and pick times. We staff the extended care service according to the times indicated on your application. The fee for extended hours is **$25 per child/per week**.

AGES

5 – 13

COST

$160.00 per week/per child; 10% discount for each additional child = $144.00 per week/per child

(Ex. 1 week - 2 children = $304.00)

Activity Fee: One time activity fee $75 (covers 8 weeks of trips and activities)

Tuition is to be paid by check or money order **(payable to SMCDC)** the **Friday** prior to the week of attendance. This amount is a flat rate for the week and will not be prorated for partial attendance.

NON-REFUNDABLE DEPOSIT

$50 per week/per child

Deposit = $50 x # of children x total # of weeks

e.g. $50 x (2 children) x (8 weeks) = $800 deposit

$5.00 for t shirt due prior to start week

$25 ADMINISTRATIVE FEE IF RECEIVED AFTER JUNE 3, 2016

EARLY REGISTRATION DISCOUNT (NON-REFUNDABLE DEPOSIT)

$35 per week/per child if received by May 20, 2016

Deposit = $35 x # of children x total # of weeks

e.g. $35 x (2 children) x (8 weeks) = $560 deposit

All forms and deposits (made payable to SMCDC) should be returned to:

ST. MATTHEW'S BAPTIST CHURCH
P. O. BOX 124
WILLIAMSTOWN, NJ 08094
ATTN: CAMP KOINONIA

YOU MAY DROP THEM OFF AT THE ADMINISTRATIVE WING ~ M-F 8:30A – 3:30P OR AT THE CAMP KOINONIA TABLE IN THE LOBBY.

WHAT TO BRING

Bible
Lunch, non-perishable, disposable container
Snack
Swimming Attire (when necessary)
Water Bottle

WHAT NOT TO BRING

Cell Phones
Magazines
Radio/CD or DVD player/CD's
Games
Toys

HOW DID YOU HEAR ABOUT CAMP KOINONIA?_____

PARENT ORIENTATION

A PARENT ORIENTATION SESSION WILL BE HELD ON **SATURDAY, APRIL 30, 2016 FROM 11:00A -1:00PM.** AT THIS TIME, YOU WILL RECEIVE AN OVERVIEW OF ALL THE ACTIVITIES FOR THE SUMMER. OUR CAMP STAFF WILL BE AVAILABLE TO ANSWER ANY QUESTIONS/CONCERNS YOU MAY HAVE. PLEASE BRING YOUR COMPLETED APPLICATION WITH PERMISSION SLIP AND PHYSICIANS.

ACTIVITIES INCLUDE

SWIMMING
ARTS & CRAFTS
BOWLING
SKATING
GAMES/SPORTS

TRIPS INCLUDE

NJ AQUARIUM
FRANKLIN INSTITUTE
PLEASE TOUCH MUSEUM
FUNPLEX
DORNEY PARK
CLEMENTON PARK
SAHARA SAMS

Camp Koinonia

REGISTRATION FORM

PLEASE PRINT CLEARLY!

√ GUARDIAN INFORMATION

LAST NAME _____

FIRST NAME _____

STREET _____ APT._____

CITY _____ STATE _____ ZIP _____

WORK/DAY PHONE _____ EVENING/HOME PHONE _____

CELL PHONE_____ PAGER _____

CHURCH HOME _____ADDRESS _____

CITY _____ STATE _____ ZIP _____

Unless otherwise indicated, all contact, correspondence and statements will be directed to the individual(s) listed above.

√ CAMPER INFORMATION

FULL NAME _____

Nickname (If applicable): _____

Age as of June 20, 2016:_____Birth date: _____ ☐ Male ☐ Female

Camp attended in 2015: Name of Camp:_____

√ WEEKS ATTENDING (CHECK ALL THAT APPLY):

☐ **Week 1 – June 20- 24**	☐ **Week 5 – July 18-22**
☐ **Week 2 – June 27-July 1**	☐ **Week 6 – July 25-29**
☐ **Week 3 – July 5-8 (July 4th is a holiday-Camp is Closed)**	☐ **Week 7 – August 1-5**
☐ **Week 4 – July 11-15**	☐ **Week 8 – August 8-12**

√ **EXTENDED HOURS REQUEST (LIST TIMES OF PICK UP AND/OR DROP OFF): _____AM _____PM**

√ ***PLEASE NOTE- IF LESS THAN FULL TIME (5 DAYS PER WEEK); PLEASE COMPLETE FORM FOR DAYS NEEDED.***

A t-shirt to be worn on **ALL Trips** will be provided for each child; please indicate size below:
Shirt Size: Youth or Adult S M L XL

√ EMERGENCY CONTACT INFORMATION

In case of an emergency we will always attempt to call the parents. However, in the event that a parent cannot be reached please provide us with at least one person to contact, preferably two. Keep in mind the hours that these numbers may be used: 7:00a-6:00p and list appropriate contacts.

FULL NAME _____ Relationship _____

Primary Phone # _____ Secondary Phone # _____

FULL NAME _____ Relationship _____

Primary Phone # _____ Secondary Phone # _____

Who will be permitted to drop off and pick up your child in addition to the parents? (List all that apply.)

Name	Relationship	Phone Number
_____	_____	_____
Name	**Relationship**	**Phone Number**
_____	_____	_____

Enrollment for part-time attendance

Please select number of days per week and specific days

☐ **3 DAYS PER WEEK (SELECT DAYS – THESE REMAIN THE SAME FOR THE DURATION OF YOUR ENROLLMENT) - $115**

☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY

MEDICAL INFORMATION TO BE COMPLETED BY GUARDIAN

Full Name _____

PLEASE PRINT CLEARLY!

Health History (√ if applicable) (Give approximate dates.)		**Allergies** (Dates not needed.)		**Diseases** (List, give approximate dates.)	
	Frequent Ear Infections		Hay Fever		
	Heart Defect/Disease		Ivy Poisoning, etc.		
	Convulsions		Insect Stings		
	Bleeding/Clotting Disorders		Penicillin		
	Hypertension		Other Drugs		
	Mononucleosis				
	Asthma	Other (Specify)			

Chronic or recurring illness or medical condition: _____

_____

Dietary restrictions: _____

_____

Does your child have any known allergic reactions to the following? (Circle all that apply) Bee Stings Peanuts Chocolate Penicillin

Other drugs, foods, seasonal allergies please describe: _____

_____

What is your child's usual reaction? (Circle all that apply.) Hives Rash Anaphylaxis

Other: _____

_____

On occasion, children develop nonspecific rashes or minor allergic reactions while at the Youth Program. Does the nurse have permission to administer Benadryl if needed (dosage based on child's age or weight)? Yes No

On occasion, children experience headaches or minor discomforts while at camp. Does the nurse have permission to administer: (dosage based on child's age or weight)?: (Circle all that apply.) Tylenol Motrin Aleve Advil

Preferred method of administration: Liquid Pill

Name of Dentist/Orthodontist: _____ Phone: _____

Name of Family Physician: _____ Phone: _____

Do you carry family medical/hospital insurance? _____ Yes _____ No

If so, indicate: Carrier: _____ Policy or Group #: _____

Suggestion on health related information for camp personnel to be aware of: _____

_____

_____

FOR FEMALE:

Has this person menstruated? _____ If not, has she been told about it? _____ If so, is her menstrual history normal? _____

Special Consideration: _____

*FOR ALL CHILDREN - P*lease circle the appropriate response:

Any Behavior Problems *Please Explain*: _____

_____

Any Learning Problems *Please Explain:* _____

_____

Important – This section Must be completed for Attendance*

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. **Authorization for Treatment:** In the event that my child (listed above) may require medical and/or surgical care while I am out of the city or unable to be reached, I hereby give my consent for medical and/or surgical treatment to the nearest hospital to provide this care. I agree to pay the entire costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent.

Signature of Parent/Guardian: _____

MEDICAL FORM TO BE FILLED OUT BY A PHYSICIAN

Child's Full Name _____

PLEASE PRINT CLEARLY!

Immunization History

Required immunizations must be determined locally. Record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) DPT* Tetanus or	1 2 3	1 2
Tetanus TD* Diphtheria or		
Tetanus		
Oral Polio (Sabin) *TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubella)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given (most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant within the past year. Date Examined _____

In my opinion, the above child's condition _____does _____ does not preclude his/her participation in an active camp program.

Height _____Weight _____ Blood Pressure_____

The applicant is under the care of a physician for the following condition(s) _____

_____

_____

Current treatment (include current medications) _____

_____

Explanation of any reported loss of consciousness, convulsion, or concussion_____

_____

Does the applicant have epilepsy? _____ Yes _____ No Does the applicant have diabetes? _____ Yes _____ No

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp: _____

_____

Any medication to be administered at camp (specific dosages): _____

_____

Activities to be encouraged or limited: _____

_____

Additional Health Information: _____

_____

_____

Licensed Physician's Signature _____

Address: _____ Phone: _____

_____

Date of Form Completion: _____ *By _____

*Initial if completed by nurse or physician's assistant.

CAMP KOINONIA
MEDICATION CONSENT

Full Name:_____

Address:_____

_____

I, _____ , parent/guardian of, _____
(Name of Parent/Guardian) (Name of Child)

who is enrolled at the above indicated camp, do hereby give the informed consent to have the following medication administered to my child.

_____ _____
Signature of Parent/Guardian Date

Medication: _____

Dosage: _____

Frequency: _____

If Over the counter…
Name/Type of medication: _____

_____

If Prescription…
Doctor's Name:_____ Prescription Number:_____

*If a prescribed medication must be administered, please make sure that the medication is in its original container with its original, proper label.

Camp Koinonia

FIELD TRIP PERMISSION SLIP

Last Name of Child:_____ First Name: _____

I give permission for my child to participate in on-site activities and to accompany staff off-site for activities. I understand that my child will be chaperoned by responsible adults while away from the facility, who will take precautions to protect my child from harm and injury.

I understand that these will be supervised activities. In order to maintain order, children will be expected to comply with rules, standards and instructions for proper behavior. I waive and release all claims against Camp Koinonia employees arising out of my child's failure to remain under such supervision. If at any time my child's behavior is incompatible with the standard for proper behavior his/her further participation may not be permitted.

In the event that my child is injured, becomes ill or involved in an accident while away, I understand that the chaperon will seek medical attention for my child, and the camp will contact me as soon as possible, and that I will be financially responsible for medical treatment. I further agree to hold Camp Koinonia and its employees harmless for any injury or illness caused by the negligence of persons other than employees of Camp Koinonia when such injury or illness occurs during the trip.

I understand that in the event that I choose not to have my child participate in a scheduled trip, I will have to find alternate care for my child for that day.

_____ _____

Signature of Parent/Guardian Date