Gentle Shepherd Christian Preschool's

2022 ADVENTURE CAMP (rain or shine)

Offered to our GSCP Family & the Outside Community



~Children Ages 2-6 Years old~ 9am-12:30 pm~

Week 1: June 13th~Week 2: June 20th

Limited Spaces Available

Join members of our GSCP staff for a fun and exciting camp on our beautiful park-like property!

Activities will include:

Sports~Science~Art~Music

What Should You Bring?

- Reusable Water Bottle labeled with name
- Lunch (no candy, soda or peanut/nut products please)
 - Yourself with Sunscreen already applied
- Medications in original bottles with prescription (including EpiPens) if applicable, along with appropriate medical releases
 - Beach Towel to sit on during outside activities

What Shouldn't You Bring?

- Snacks (we will provide them)
- Sunscreen (unless you have a documented need for re-application)

To Register:

Current GSCP & Childcare Families:

Please fill out registration form and return to GSCP office along with all fees. Please make checks payable to SHLC. Fees are non-refundable.

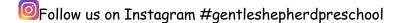
Families from outside of GSCP:

Please fill out registration form and return to GSCP office (drop-off or mail) along with all fees.

Please make checks payable to SHLC. Fees are non-refundable.

In addition, please provide GSCP with an up-to-date completed Universal Health Form along with a record of your child's current immunizations. If your child has allergies or other medical needs, please complete the Children with Special Health Needs Form with instructions (i.e. EpiPen).

- Spaces available on a first-come, first-served basis
 - Fee is \$289/week or \$550/2 weeks
 - Sibling Discounts on next page
 - Checks can be made payable to: SHLC
 - Fees are non-refundable



Follow us on Facebook @baskingridgepreschool

Gentle Shepherd Christian Preschool 350 Lake Road Basking Ridge, NJ 07920 Krissy Hosler, Director Gentle Shepherd Christian Preschool gscp@shlc.net 908-766-1430

Child's Name:				Er	Email:			
Parent/Guardian Name:					Cell Phone:			
Parent/Guardian Name:								
Address:				Ce	ell Phone:			
Best Way to Contact	† Υοι	ı Duri	ng Camp:					
•				Camp Hours:				
				·				
Insurance Co. Name	:		Pc	olicy #:	Phone:			
Parent Signature:					Todav's Dat	e:		
Taroni oignararo.					1000,500			
Name		500	المالية والمالية	Designation For One Time Courily F	haz-iz-1	NA/IA 2		
Name	Age	DOB	Allergies & Medical Concerns	Registration Fee~One Time Family F \$10 per current GSCP Family	ee Week 1 6/14-6/18	Week 2 6/21-6/25		
				\$20 per outside GSCP Family	\$289/week	\$289/week \$550/2 weeks		
1.								
2.								
_								
3.								
Please Subtract Any Dis	count	ts Acc	ording to the Info	Below				
Total Due								

Sibling Discount:

If a sibling is attending the same week of camp, please take \$15 off of the second child's total.

If a sibling is attending the same 2 weeks of camp, please take \$50 off the second child's total.

If multiple siblings are attending, each additional sibling may apply the same discount.

Current Families:

Please return this form only. Keep the first page for your records.

Outside Families:

Please return this page, universal health form, proof of immunizations, children with special health needs form, awareness statement, emergency contact and media release form.

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EMERGENCY MEDICAL RELEASE

In the event of a medical emergency, I give permission to the Director and/or her designee of Gentle Shepherd Christian Preschool & Somerset Hills Lutheran Church to seek medical attention for my child. This includes, but is not limited to contacting 911 for assistance, hospitalization, and any life saving measures deemed appropriate by emergency medical personnel and hospital staff where applicable. Every effort will be made to contact you prior to the involvement of emergency medical personnel.

I grant permission		I do not grant permission
Parent/Guardian's Nan	ne Printed:	
Parent/Guardian's Sign	nature:	
Date:		
	<u> PHOTO/</u>	RECORDING RELEASE
Christian Preschool or may not include p	for the purpose of s rinted materials incl and Instagram page.	raph/recording of my child to be used in Gentle Shepher haring camp photos for families and advertising. This mouding in-school displays, brochures and on the school's Your child's name will never be printed without express uardian.
I grant permission		I do not grant permission
Parent/Guardian's Nan	ne Printed:	
Parent/Guardian's Sign	nature:	

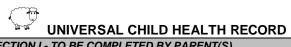
Date:



The information provided be	elow is the information we will use in an emergency. Your child's health
information and this Emerge	ency Form will be duplicated and taken out of the building with us if there
were a time that we had to	vacate the building due to an emergency. It is imperative that when your
child i	is in our care that <u>parents are always reachable.</u>

Telephone numbers in the order we should call if we have not been able to reach you. We would call due to illness, early dismissal/delayed opening, or an emergency at school. You must list at least 3 contacts (use the back of this page to add additional contacts if needed). The following people are authorized by you to pick up your child if either parent cannot be reached or is unavailable.

Child's Full Name:	DOB:	Home Address:
Mother's Name:	Cell Phone:	Other Phone:
Father's Name:	Cell Phone:	Other Phone:
L	ist of Contacts if Parent	ts Unreachable
Name:	Relationship:	Cell Phone:
		Other Phone:
Name:	Relationship:	Cell Phone:
		Other Phone:
Name:	Relationship:	Cell Phone:
		Other Phone:
Pediatrician Name:		Phone:
Preferred Hospital:	List All Allergies:	



SECTION I - TO BE COMPLETED BY PARENT(S)												
Child's Name (Last)			(/	First)	(Gen	der		Date of B	irth		
							Male	Female)	/	/	
Does Child Have Health Insurance?		If Yes, Nam	e of Chil	d's Health Insuran	ce Carrie	er						
Yes No				Hama Talaahaaa	Nimaka			ı	10/aul. Talaubaua	/Call Dha	a a Niversia a s	
Parent/Guardian Name				Home Telephone	Numbei	r			Work Telephone	/Cell Pho	ne Number	
Parent/Guardian Name				Home Telephone	Number	r			Work Telephone	/Cell Pho	ne Number	
I give my consent for my child's Healt	h Care I	Provider a	nd Ch	ild Care Provid	der/Sci	hoo	l Nurse to di	scuss	the informati	ion on t	his form.	
Signature/Date			This form may be released to				to					
							WIC. Yes No					
SECTIO	N II - TO) BE CON	IPLETI	ED BY HEALTH	H CAR	E PI	ROVIDER					
Date of Physical Examination:							examination n	ormal?	Yes	;	No	
Abnormalities Noted:					1 7		Weight (must	be taker	within			
							30 days for W Height (must l		within			
							30 days for W	IC)				
							Head Circumf (if <2 Years)	erence				
							Blood Pressur (if >3 Years)	е				
IMMUNIZATIONS			<mark>Immu</mark> Attac	unization Record	<mark>i</mark>							
				Next Immunizat								
				CAL CONDITION								
Chronic Medical Conditions/Related Surgeries List medical conditions/ongoing surgical conce	erns:		None Speci Attac	ial Care Plan	Comm	ents	5					
Medications/Treatments			None		Comm	ents	3					
List medications/treatments:			Attac	ial Care Plan hed								
Limitations to Physical Activity			None Speci	ial Care Plan	Comments							
List limitations/special considerations:			Attac	hed	0							
Special Equipment Needs List items necessary for daily activities			None Speci Attac	ial Care Plan	Comments							
Allergies/Sensitivities			None	ial Care Plan	Comm	ents	3					
List allergies:			Attac									
Special Diet/Vitamin & Mineral Supplements			None	ial Care Plan	Comm	ents	3					
List dietary specifications:			Attac									
Behavioral Issues/Mental Health Diagnosis			None		Comm	ents	3					
List behavioral/mental health issues/concerns	:		Speci Attac	ial Care Plan hed								
Emergency Plans			None		Comm	ents	3					
 List emergency plan that might be needed and sign/symptoms to watch for: 	d the		Speci Attac	ial Care Plan hed								
PREVENTIVE HEALTH SCREENINGS												
Type Screening	Date Pe	erformed	F	Record Value		Ту	pe Screening	9	Date Perform	ned	Note if Abnormal	
Hgb/Hct			1		He	aring	g					
Lead: Capillary Venous			1			ion						
TB (mm of Induration)			1			ntal						
Other:			†		De	velo	pmental					
Other:			†			olios						
I have examined the above student and rev					nat he/sl			red to pa	articipate fully in	n all child	d care/school	
activities, including physical education and Name of Health Care Provider (Print)	competit	ive contact	sports,			are	Provider Stan	nn.				

TO BE COMPLETED ONLY IF A CHILD HAS SPECIAL HEALTH NEEDS



Please be advised of the following:

- 1. There is no nurse on staff at Gentle Shepherd Christian Preschool.
- 2. The staff attends CPR, First Aid, AED training annually but has no medical training to recognize and treat symptoms of chronic medical illnesses or allergies, such as diabetes, asthma, cystic fibrosis and/or severe allergies.
- 3. Each chronic medical condition must be presented to and discussed with the Director of Gentle Shepherd Christian Preschool prior to enrollment.
- 4. The school will not be responsible for providing "special snacks" for students with food allergies or diabetes.
- 5. School snacks are purchased in volume for the school. Parents of children with food allergies are asked to look at what is being provided to the class and if there is a food allergy concern that our snacks have we ask parents to provide a special snack for their child.
- 6. The school imposes no restriction on food brought into the classroom, building or Lunch Bunch. Although parents are educated about food allergies, it is likely that food containing peanut products, wheat and dairy will be present throughout the school.
- 7. There are no special seating arrangements at Lunch Bunch.
- 8. The classrooms are multipurpose rooms used by many groups outside and inside the Church and, therefore, not solely under the control of Gentle Shepherd Christian Preschool.
- 9. We cannot control what children eat at home and what they may bring in on their hands and clothes.

We have read and understand the Gentle Shepherd Christian Preschool Awareness Statement for Chronic Medical Conditions and the Chronic Medical Policy. We believe that						
(Child's Name)	can attend Gentle Shepherd Chr	istian Preschool.				
Parent's Name	 Parent's Signature	 Date				
Physician's Signature	 Date					

TO BE COMPLETED ONLY IF A CHILD HAS SPECIAL HEALTH NEEDS



EMERGENCY MEDICAL PROTOCOL

Name			
Date of Birth		Child's Pho	01
Medical Condition		_	
Asthmatic			
SIGNS OF MEDICAL COND	ITION/ALLERGY:		
Symptoms:			
CUT			
LUNC			
LICART			
ACTION PLAN/MEDICAL PR	ROTOCOL:		
2			
4.			
CALL:			
1.			
2.			
3			
4.			
Any medication left with the s Pharmacy with child's name an	- •	be in original package as dispensed fror	n
Parent Signature & Date	Parent Signature & Date	Physician Signature & Date	
EMERGENCY CONTACTS (no	ame and cell phone #):		
1	3		
2.	4.		