Child's First Name _____ MI ___ Last Name _____ DOB ___ - ___ - 20__
MONTH DAY YEAR

Please do not cover barcode

Please provide information for the **CHILD's PRIMARY PARENT/GUARDIAN.**

This person will receive verbal and written application updates and communication from us.

Parent/Guardian 1 First Name: _____ **Last Name:** _____

Email Address: _____ **Preferred to be contacted by:** ☐ Email ☐ Primary Phone

Mailing Address: _____ **Apt #:** _____

Mailing City: _____ **Borough:** _____ **Mailing Zip:** _____

Cell (: _____ **Home (:** _____ **Work (:** _____

Which number is your primary phone number? ☐ Cell ☐ Home ☐ Work

* **Relationship to child:** ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____ ☐ **Currently living with child**

**** Please note**: If you are not the mother or father, you must provide a copy of court–approved guardianship papers.*

Please provide information for the **SECONDARY PARENT/GUARDIAN**.

☐ **No secondary parent/guardian**

Parent/Guardian 2 First Name: _____ **Last Name:** _____

Email Address: _____

Cell (: _____ **Home (:** _____ **Work (:** _____

* **Relationship to child:** ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____ ☐ **Currently living with child**

☐ This person can receive verbal application updates

☐ This person can pick up child upon return from summer experience

Please tell us about your **HOUSEHOLD**.

1. **Preferred language to communicate with The Fresh Air Fund:**
   ☐ English ☐ Spanish ☐ Mandarin ☐ Other: _____
2. **Language(s) spoken at home:** *(check all that apply)*
   ☐ English ☐ Spanish ☐ Mandarin ☐ Cantonese ☐ Creole ☐ Korean ☐ French ☐ Other: _____
3. **Is your child your regular interpreter?** ☐ Yes ☐ No
4. **Household type:** ☐ Single parent/guardian ☐ Two parents/guardians ☐ Other: _____ ☐ Prefer not to say
5. **Total number of ADULTS (18+) in household:** 1 2 3 4 5 Other: _____
6. **Total number of CHILDREN (up to age 17) in the household:** 1 2 3 4 5 6 7 8 Other: _____
7. **Is your family currently homeless or living in temporary shelter?** ☐ Yes ☐ No
   If yes, where are you living? ☐ In a shelter ☐ With family/friends ☐ Other:_____ ☐ Prefer not to say
8. **Is Parent/Guardian a former Fresh Air participant?** ☐ Yes ☐ No

If applying for the first time, how did you hear about us?

☐ Ad ☐ Flyer ☐ Friend/Family ☐ Website ☐ Community Partner (name) _____

☐ School (name) _____ ☐ Other: _____

OFFICIAL USE ONLY **Date Received by FAF:** _____

Source: ☐ Email ☐ Fax ☐ Mail ☐ Phone ☐ Community Partner: _____
☐ FT Ambassador _____ ☐ School Event ☐ Summer in the Winter Party ☐ Street Outreach ☐ Walk-in
☐ Other _____ **FAF STAFF INITIALS** _____

Please **PRINT** clearly and use **INK** pen.

Please do not cover barcode

Please tell us about your **CHILD**. ***Note: Child must be 7 years old by 08/10/2020 to participate.***

Child First Name: _____ **M.I.** _____ **Last Name:** _____

Nickname: _____ **Date of Birth:** ___ – ___ – 2 0 ___ ___
MONTH DAY YEAR

Gender: ☐ Male ☐ Female ☐ Other: _____ **Age:** 6 7 8 9 10 11 12 13 14 15 16 17 18

Preferred Pronoun: ☐ She, her, hers ☐ He, him, his ☐ They, them, theirs

Race/Ethnicity: ☐ African American/Black ☐ African ☐ American Indian/Alaskan Native ☐ Asian ☐ Hispanic/Latino
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other: _____ ☐ Prefer not to say

---

Please tell us about your **CHILD's SCHOOL**.

School Name: _____ **School Borough:** _____ **2019-2020 Grade:** _____

Type: ☐ Charter ☐ Public ☐ Independent/Private ☐ Parochial/Religious ☐ Other: _____

Please tell us more about your **CHILD**.

1. **Has your child ever spent the night away from home?** ☐ Yes ☐ No **If Yes, how many nights?** _____
2. **Child's T-shirt Size:** *(Pick one)* **Youth:** ☐ S ☐ M ☐ L **Adult:** ☐ S ☐ M ☐ L ☐ XL ☐ Other
3. **Is your child in foster care?** ☐ **Yes** ☐ **No** *(If Yes, additional form required - Foster Care Info Page [FC1])*
4. **Does your child receive public assistance?** ☐ **Yes** ☐ **No** If yes, *check all that apply*
   ☐ Cash Assistance ☐ TANF ☐ SNAP ☐ Other: _____
   Please provide Cash Assistance Case Number: _____
   Please Provide SNAP Case Number: _____
5. **Please tell us your child's comfort level with communicating in English:**
   ☐ Only speaks English / Fluent in English
   ☐ English is second language but comfortable speaking to others in English
   ☐ Learning English / Speaks very little English - Native language: _____ (☐ In ELL / ENL classes in school)

Please tell us about the **SERVICES** your **CHILD** receives in or out of school. ***Please answer both questions.***

1. **Mark all SERVICE(S) your child receives:**
   (Must check at least one)
   - ☐ IEP (Individualized Education Plan) *(i.e. Special Needs Program/Classes, including SETTS)*
   - ☐ 1:1 Paraprofessional
   - ☐ Counseling/Therapy (in or out of school)
   - ☐ 504 Accommodations. Please explain below.
   - ☐ Other. Please explain below.
   - ☐ None

2. **Mark all service PROVIDER(S) your child sees:**
   (Must check at least one)
   - ☐ Psychiatrist
   - ☐ Psychologist
   - ☐ Social Worker
   - ☐ Other. Please explain below.
   - ☐ None

Please explain as indicated above. _____

_____

If you marked any box above, please call 1-800-367-0003 to get The Fresh Air Fund's Evaluation Form.
This information helps in making the best programming decisions for your child and allows us meet their needs and offer a safe experience.

Must be completed by Parent/Legal Guardian (See **Page vi** for instructions)

Please do not cover barcode

PART 1.	PART 2.	
Enter Child's First & Last Names	**Enter Case #** if child receives SNAP/TANF/FDPIR. Then go to Part 4.	**Check If Child Is in Foster Care** Children in foster care are eligible for free/reduced-price meals regardless of household income. Then go to Part 4.
		☐

PART 3. Total Household Gross Income. If child does not receive SNAP/TANF/FDPIR and is not in foster care, please tell us how much you earn and how often it is received.

List all earnings from: work; welfare; child support; alimony; pensions; Social Security; retirement; SSI; VA benefits; or other income sources. Include frequency (e.g. yearly, monthly, bi-weekly, or weekly). Then go to Part 4.

Name(s)	Gross Income by Source								
Enter the name of each person living in your household	Income from Work before Deductions		Income from Welfare, Child Support, or Alimony		Income from Social Security, Pension, Retirement, SSI, or VA Benefits		All Other Income		Check if NO Income
	$	Frequency	$	Frequency	$	Frequency	$	Frequency	
									☐
									☐
									☐
									☐
									☐
									☐

PART 4. Signature and Social Security Number (Parent/Guardian must sign). Then go to Part 5.

A parent/guardian living in the household must sign this form. The person signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See statement in the information packet.)

I certify that all information on this application is true and that all income is reported. I understand that this information is being given for the receipt of Federal funds. I understand that SFSP officials may verify [check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

Sign Here: _____ Print Name: _____

Date: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code _____

Last four digits of Social Security Number: * * * - * * - _____ ☐ I do not have a Social Security Number

Must be completed & signed

PART 5. ETHNICITY & RACIAL IDENTITY (Optional)

Mark one ethnic identity	Mark one or more racial identities
☐ Hispanic or Latino ☐ Non-Hispanic or Latino	☐ Asian ☐ Black/African American ☐ White ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

DO NOT WRITE BELOW THIS PART. IT IS FOR OFFICIAL USE ONLY.

Total Income: $_____ Per: ☐Week, ☐ Every 2 Weeks, ☐Twice A Month, ☐Month, ☐Year Household size:

Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: ☐ **Free** ☐ **Reduced** ☐ **Denied**

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Verifying Official's Signature: _____ Date: _____

Annual Income Conversion:
Weekly x 52
Every 2 Weeks x 26
Twice A Month x 24
Monthly x 12

Child's First Name _____ MI ___ Last Name _____ DOB ___ - ___ - 20__
MONTH DAY YEAR

Please do not cover barcode

Please tell us about your **CHILD's HEALTH HISTORY**.

Has/does your child...		YES/SI	NO
1	Had a recent injury, illness or infectious disease?	☐	☐
2	Had a chronic or recurring illness/condition?	☐	☐
3	Have asthma?	☐	☐
4	Have allergies?	☐	☐
5	Ever been hospitalized?	☐	☐
6	Ever had surgery?	☐	☐
7	Had frequent headaches?	☐	☐
8	Ever had a head injury?	☐	☐
9	Ever been knocked unconscious?	☐	☐
10	Ever had frequent ear infections?	☐	☐
11	Ever been diagnosed with a heart murmur?	☐	☐
12	Ever had seizures/have a seizure disorder?	☐	☐
13	Had skin problems (e.g. itching, acne, eczema)?	☐	☐
14	Been treated for head lice in last six months?	☐	☐
15	Ever had problems with frequent diarrhea/constipation?	☐	☐
16	Ever had an eating disorder?	☐	☐
17	Wear glasses, contacts or protective eye wear?	☐	☐
18	**If female**, begun to menstruate?	☐	☐
	If not, does she know about the menstrual cycle?	☐	☐
19	Know how to swim? (If yes, no explanation needed)	☐	☐
20	Have a fear of being in the water?	☐	☐
21	Have a fear of being around animals?	☐	☐
22	Wet his/her bed?	☐	☐
	If yes, how often?	_____	
	If yes, is it a medical issue?	☐	☐
23	Have motion sickness?	☐	☐

Please explain all 'Yes' answers. Include the question number and the most recent occurrence./***Por favor explique todas las respuestas de 'Sí'.*** *Incluya el número de la pregunta y el caso más reciente.*

_____

_____

_____

_____

_____

_____

_____

_____

Child's First Name _____ MI ___ Last Name _____ DOB ___ - ___ - 20__ (MONTH DAY YEAR)

Please do not cover barcode

Please tell us more about your **CHILD's HEALTH HISTORY**

1. Does your child have one of the following physical or medical conditions?

(Please check all that apply or "None")

- ☐ Cerebral Palsy
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Hearing Impairment
- ☐ Hydrocephalus
- ☐ Visual Impairment
- ☐ Seizure Disorder
- ☐ Sickle Cell Disease
- ☐ None
- ☐ Other *(please explain)* _____

2. Does your child have one of the following behavioral, cognitive, social or emotional conditions?

(Please check all that apply or "None")

- ☐ ADHD
- ☐ Adjustment Disorder
- ☐ Autism Spectrum Disorder
- ☐ Disruptive Mood Dysregulation Disorder
- ☐ Down Syndrome
- ☐ Emotional Disturbance
- ☐ Intellectual Disability
- ☐ Oppositional Defiant Disorder
- ☐ None
- ☐ Other *(please explain)* _____

3. Does your child currently have any other physical, mental, emotional, social health, developmental or psychological condition that will require medication, treatment or special restrictions or considerations during the program?

☐ Yes ☐ No If Yes, please explain: _____

4. Does your child have any activity exemptions, restrictions or limitations?

☐ Yes ☐ No If Yes, please explain: _____

Child's First Name _____ MI ___ Last Name _____ DOB ___-___-20__ (MONTH DAY YEAR)

Please do not cover barcode

Please tell us about your **CHILD's HEALTH INSURANCE COVERAGE.**

Check one of the following / *Marque uno de los siguientes*:

☐ **Child has private health insurance (e.g. through my employer or the open market)**
El niño tiene seguro médico privado (por ejemplo, a través de mi empleador o el mercado abierto)

Policy includes dental coverage / *Póliza incluye cobertura dental* ☐ Yes/Sí/是 ☐ No/没有

☐ **Child has health insurance through NYS Medicaid**
El niño tiene seguro de salud a través de Medicaid del Estado de Nueva York.

If applicable, check provider and submit copy of insurance card with Medicaid card:
Si corresponde, consulte al proveedor y envíe una copia de la tarjeta de seguro con la tarjeta de Medicaid:

☐ **Fidelis** ☐ **HealthFirst** ☐ **MetroPlus** ☐ **Other:** _____

☐ **Child is in foster care** / *El niño está en cuidado de crianza*

☐ **Child does not have health insurance** / *El niño no tiene seguro de salud*

Would you like a referral to help you get health insurance? ☐ Yes/Sí/是 ☐ No/没有

A clear copy (front and back) of your child's health insurance card(s) is required/
Se requiere una copia clara (anverso y reverso) de la (s) tarjeta (s) de seguro de salud de su hijo

Please tell us more about your **CHILD's HEALTH INFORMATION**

1. **Does your child have any dietary restrictions (e.g. vegetarian, no pork, lactose intolerant, gluten-free)?** /
¿Su niño tiene alguna restricción dietética (ej. Vegetariano, no come cerdo, intolerante a lactosa, libre de gluten)?
☐ Yes/Sí Please explain / *por favor explique*: ☐ No red meat ☐ No poultry ☐ No pork ☐No seafood
☐ No ☐ No eggs ☐ No dairy product ☐ Other: _____

These dietary restrictions are due to: / *Estas restricciones dietéticas son debido a:*
☐ **Allergies/Medical Condition(s)** ☐ **Religious Beliefs** ☐ **Personal Preferences** ☐ **Other** _____
Alergias/Condiciones médicas *Creencias religiosas* *Preferencia personal* *Otro*

2. **Is your child currently taking any medication? / ¿Su niño esta actualmente tomando algún medicamento?**
☐ Yes/Sí Please explain / *por favor explique*: _____
☐ No

3. **Has an epi-pen been prescribed for your child?** */¿Su niño ha tenido una prescripción para una inyección de epinefrina?*
☐ Yes/Sí Please answer the questions below
☐ No

a. **Has the prescription been filled?** ☐ Yes/Sí ☐ No

b. **Has the epi-pen ever been used?** ☐ Yes/Sí Date/approximate date most recently used: ___-___-____ (MONTH DAY YEAR)
☐ No

c. **Does your child know how to inject him/herself?** / *¿Su niño sabe como inyectarse?* ☐ Yes/Sí ☐ No

Please note / Por favor note: *If an epi-pen is prescribed, it is required during Fresh Air Fund trip. / Si su niño tiene una prescripción para una inyección de epinefrina (Epi-pen), es requerida durante su experiencia con el Fresh Air Fund.*

Child's First Name _____ MI ___ Last Name _____ DOB ___ - ___ - 20__
MONTH DAY YEAR

Please do not cover barcode

To be completed by Parent/Guardian.

Meningococcal Meningitis Vaccination Response Form

New York State Public Health Law requires that a parent or guardian of a child who attends an overnight children's camp for seven (7) or more consecutive nights, complete and return the following form to the camp.

Check one box and sign below.

☐ My child has had the meningococcal conjugate vaccine -MCV4 (ex. Menactra or Menveo).

Date received: _____/_____/_____
MONTH DAY YEAR

[Note: The Centers for Disease Control and Prevention recommends two doses of MCV4 for all adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at age 16. Adolescents in this age group with HIV infection should get three doses: 2 doses 2 months apart at 11 and 12, plus a booster at age 16.

If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, the booster is not needed.]

☐ My child is not 11 years old yet and does not require the meningococcal Meningitis Vaccination.

☐ My child will not obtain immunization against meningococcal meningitis disease. I have read, or have had explained to me, the information about meningococcal meningitis disease and vaccination. I understand the risks of not receiving the vaccination.

Please provide all information.

Parent Signature: _____ **Date:** _____/_____/_____
MONTH DAY YEAR

Print Name: _____

Email Address: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Child's First Name _____ MI ___ Last Name _____ DOB ___ - ___ - 2 0 ___
MONTH DAY YEAR

Please do not cover barcode

Please give your consent for your **CHILD to visit the VISION VAN at Camp.**

Your child is eligible to receive a **free eye examination and pair of glasses** during camp through our partnership with OneSight, a leading vision care nonprofit which provides comprehensive eye exams and stylish glasses, if needed. **Both the examination and eyewear will be donated by OneSight.**

PLEASE SELECT ONE OPTION IN EACH SECTION BELOW AND SIGN AND DATE THIS FORM.

☐ **I Do** ☐ **I Do Not** **Give my permission for my child to receive a free eye exam and glasses,** if needed, at the OneSight Vision Clinic at camp this summer.

☐ **I Do** ☐ **I Do Not** **Give my permission for the optometrist to perform a dilated fundus exam** during the examination process at the OneSight Vision Clinic.

The state board of optometry may require a dilated fundus exam as part of an eye examination performed by a licensed optometrist. A dilated fundus exam is a thorough exam of the peripheral retina aided by the use of topical dilating eye drops. This procedure is used to diagnose abnormalities of the retina such as detachments, tears, tumors, infections, hemorrhages and genetic abnormalities. The dilating drops will leave the pupils dilated for approximately four hours. During this period the patient may experience blurry vision and light sensitivity which may make reading difficult.

☐ **I Do** ☐ **I Do Not** **Give my permission for my child to be filmed or photographed** and understand that my decision will not affect whether my child receives an eye exam or glasses at the Clinic.

Release of Liability

By signing below, I release and discharge from any and all claims, demands and liability arising out of this event or any use granted herein the officers, directors, employees, agents, affiliates, and/or assigns of the following groups: The Fresh Air Fund personnel; the independent optometrist(s) who perform the eye exam; any co-sponsoring agency; and OneSight.

Signature of parent or legal guardian: _____ **Date:** _____/_____/_____

Please share some additional **HEALTH INFORMATION**.

In order to help facilitate the eye exam, please complete this brief health history for your child.

Does your child or any immediate family member (parent, grandparent, sibling) have any of the following?

Diabetes ☐ **No** ☐ **Yes** If yes, who? _____

Glaucoma ☐ **No** ☐ **Yes** If yes, who? _____

High Blood Pressure ☐ **No** ☐ **Yes** If yes, who? _____

Does your child currently wear glasses? ☐ **No** ☐ **Yes**

Has your child ever worn glasses? ☐ **No** ☐ **Yes**

Does your child have any known ALLERGIES? ☐ **No** ☐ **Yes**, If yes, please list: _____

Is your child currently taking any MEDICATION? ☐ **No** ☐ **Yes**, If yes, please list: _____

Please list any known problems or symptoms your child has in regards to his/her vision and/or eye health: _____

_____

_____

Child's First Name _____ MI ___ Last Name _____ DOB ___ - ___ - 20__ (MONTH - DAY - YEAR)

Please do not cover barcode

Please tell us more about your **CHILD**.

Has your child been adjusting to any of the following changes in the last year?

☐ New school ☐ New brother/sister ☐ Loss of a close friend ☐ Divorce or separation of parents

☐ Death of: _____ ☐ Other changes: _____ ☐ No changes

Please complete the rest of this page if you are applying for the **Friendly Towns** program.

My child is generally *(check all that apply)*: ☐ Active ☐ Athletic ☐ Attached to Parent/Guardian

☐ Cheerful ☐ Curious ☐ Easily Frustrated ☐ Easy Going ☐ Fearful ☐ Helpful

☐ Immature ☐ Independent ☐ Irritable ☐ Joyful ☐ Mature ☐ Outgoing

☐ Quiet ☐ Sad ☐ Shy ☐ Talkative ☐ Other _____

Please ask your child what they are interested in doing with their host family *(check all that apply):*

☐ Swimming & Water Activities
☐ Exploring Nature (Hiking / Fishing)
☐ Bike Riding
☐ Camping
☐ Cooking / Baking
☐ Arts & Crafts
☐ Sports (Basketball / Soccer)
☐ Watching TV / Movies
☐ Attending Community Events
☐ Picnicking / Going to Playgrounds / Playing Outdoors
☐ Reading

☐ Other *(Please Explain)* _____

Use this space to provide any additional information about your child that you feel would be helpful for our staff or host families to know: _____

_____

_____

During my child's visit, we prefer that *(check all that apply)*:

1. The family has ☐ 3 or more children ☐ 1-2 children ☐ No children ☐ No preference

2. The family has children that are ☐ Older ☐ Younger ☐ Same Age ☐ No preference

3. My child prefers: ☐ Large Groups ☐ Small Groups ☐ No Preference

---

What are your child's favorite foods? _____

_____

Child's First Name _____ MI ___ Last Name _____ DOB ___ - ___ - 20___ (MONTH - DAY - YEAR)

Please do not cover barcode

Please indicate preferred program:

☐ Friendly Towns ☐ Camp ☐ Camp Junior ☐ ABC Leadership ☐ CAP ☐ Explorers ☐ CIT

Please complete information for all programs of interest. We will try to accommodate your choices. Placement is not guaranteed.

Friendly Towns (Host Family Program)

My child is available to travel as follows:

Check all that apply. The dates below are time frames, not exact trip dates. Trips for first time participants are only 7-10 days.

Early July	☐	June 29 - July 11
Late July	☐	July 12 - July 31
Early August	☐	August 1 - August 8
Mid-Late August	☐	August 9 - August 20

I am interested in my child visiting a family in the following area(s):

(Check all that apply)

☐ Connecticut	☐ New Hampshire	☐ Rhode Island
☐ Delaware	☐ New Jersey	☐ Virginia
☐ Maine	☐ New York	☐ Vermont
☐ Maryland	☐ North Carolina	☐ Ontario, Canada
☐ Massachusetts	☐ Pennsylvania	☐ Not Sure / No Preference

If interested in child visiting a family in Canada:

Does child have a valid U.S. passport? ☐ Yes ☐ No

If yes, when does it expire? ___ - ___ - ___ (MONTH - DAY - YEAR)

****A copy of child's U.S. passport is required****

Returning Participants Only:

Does your child want to return to their Summer 2019 host family if they are available?

☐ Yes ☐ No

Summer Camp & Camp Junior

Summer Camp	Camp Junior
• Girls 8-13 and Boys 8-15	• Bronx residents only
• ABC Leadership: Must have attended Camp ABC, Hidden Valley or Camp Mariah and be invited to apply	• New: Girls & Boys 9-13
	• Returning: Girls & Boys 9-15

Using 1 - 4, please indicate session preferences:

1 for 1st Choice, 4 for 4th Choice

Session 1	☐	June 29 - July 10 (12 days)
Session 2	☐	July 13 - July 24 (12 days)
Session 3	☐	July 27 - August 7 (12 days)
Session 4	☐	August 10 - August 21 (12 days)

*** CITs must attend all 4 sessions**

If Camp is full, please consider my child for the Friendly Towns Program.

☐ Yes ☐ No

Please Note:

Children must participate in the full session/trip and use transportation arranged by The Fresh Air Fund.

Sessions/trips are not allowed to start late or end early.

Career Awareness Program/Camp Mariah

New CAP applicants must be:

- 11 or 12 years old on the first day of the program (06/29)
- In the 6th grade when they apply
- Willing to commit to 3-year program including school year activities
- Interviewed by program staff

Returning CAP campers attend same session as Summer 2019.

New applicants, please indicate session preferences:

1 for 1st Choice, 2 for 2nd Choice

Session 1	☐	June 29 - July 22 (24 days)
Session 2	☐	July 29 - August 21 (24 days)

Explorers Summer Learning Program

Applicants must be:

- 11 or 12 years old on the first day of the program (07/13)
- In the 6th grade when they apply
- At Camp for the full 26-day session
- Interviewed by program staff

Session	☐	July 13 - August 7 (26 days)

Child's First Name _____ MI ___ Last Name _____ DOB ___ - ___ - 20__
MONTH DAY YEAR

Please do not cover barcode

Please provide **EMERGENCY CONTACT** information.

Please provide information for **three (3) adults** we can contact if we are unable to reach you about this application or during your child's trip. Emergency Contacts **CANNOT** be the primary or secondary contacts listed on page 1 of this application, and must each have a unique phone number and email address. They **MUST BE 18 YEARS OR OLDER** and **BE AUTHORIZED TO PICK UP YOUR CHILD** if you are unable to do so on either the scheduled return date or if your child must return home early from their camp or their host family experience.

Emergency Contact 1

First Name: _____ **Last Name:** _____

Relationship to child: ☐ Aunt ☐ Uncle ☐ Grandparent ☐ Cousin ☐ Family Friend ☐ Other: _____

18 or older? ☐ Yes ☐ No

Cell (: _____ **Home (:** _____ **Work (:** _____

Email Address *(optional)*: _____

Preferred language : ☐ English ☐ Spanish ☐ Mandarin ☐ Cantonese ☐ Korean ☐ Other: _____

Emergency Contact 2

First Name: _____ **Last Name:** _____

Relationship to child: ☐ Aunt ☐ Uncle ☐ Grandparent ☐ Cousin ☐ Family Friend ☐ Other: _____

18 or older? ☐ Yes ☐ No

Cell (: _____ **Home (:** _____ **Work (:** _____

Email Address *(optional)*: _____

Preferred language : ☐ English ☐ Spanish ☐ Mandarin ☐ Cantonese ☐ Korean ☐ Other: _____

Emergency Contact 3

First Name: _____ **Last Name:** _____

Relationship to child: ☐ Aunt ☐ Uncle ☐ Grandparent ☐ Cousin ☐ Family Friend ☐ Other: _____

18 or older? ☐ Yes ☐ No

Cell (: _____ **Home (:** _____ **Work (:** _____

Email Address *(optional)*: _____

Preferred language : ☐ English ☐ Spanish ☐ Mandarin ☐ Cantonese ☐ Korean ☐ Other: _____

Child's First Name _____ MI ___ Last Name _____ DOB ___ - ___ - 2 0 ___
MONTH DAY YEAR

Please do not cover barcode

Please read, sign and date both **PARENTAL CONSENT & RELEASE FORMS** *(pages 12 and 13)*

As the parent/guardian of the above-named child ("My Child"), I agree that My Child may participate in The Fresh Air Fund's (The Fund) summer sleepaway programs and associated activities ("Fresh Air Activities") in either Fishkill, NY, Harriman State Park (NY) or along the East Coast and Southern Canada, as more fully described in The Fund's promotional materials. I permit My Child to travel between The Fund's designated transportation hubs and the assigned program location by bus, train, automobile, plane, taxi, car service, subway, or any other means necessary. I understand that participating in Fresh Air Activities is wholly voluntary. Additionally, I permit My Child to participate in Fresh Air Activities including, but not limited to: camping, swimming, boating, rope and challenge courses, biking, hiking, and other activities described and shown in brochures and other marketing materials.

I understand that I may receive as much information from The Fund with respect to The Fresh Air Activities as I deem desirable and will have the opportunity to discuss the Fresh Air Activities with members of The Fund's staff and/or volunteers prior to My Child participating in The Fresh Air Activities. I understand that I am responsible for making my own independent assessment of the risks to My Child of participation in Fresh Air Activities, including the risks associated with travel, camping, swimming, boating, rope and challenge courses, biking, hiking and other activities included in Fresh Air Activities.

I am aware that travel and the activities included in Fresh Air Activities can be dangerous and can involve risks of serious injury and even death. I understand that, although Fund Agents (as defined below) will chaperone Fresh Air Activities, My Child will be unsupervised at times during participation. I agree that The Fund is not an insurer of the health or safety of My Child. I also agree that The Fund does not assume responsibility for spontaneous and unforeseen events that may occur during My Child's participation in Fresh Air Activities.

I am aware that The Fresh Air Fund conducts short surveys with youth participants to get feedback on things like what they liked or didn't like and to understand if the program helped their personal development. My child's participation in these activities is voluntary. We do not anticipate that participation will result in distress on the part of your child. If you would like further information about our program evaluation work or if you do not want your child to participate in these activities, please contact The Fresh Air Fund at (212) 897-8900 or email us at: programevaluation@freshair.org prior to your child's program start date.

In consideration of The Fund permitting My Child to participate in Fresh Air Activities:

I, on behalf of My Child, myself, my spouse, my domestic partner and all other family members and the heirs, agents, executors, administrators, representatives and assigns of each of the foregoing and all persons claiming under them (collectively, the "Child Parties"), assume all risks involved in Fresh Air Activities. I agree that neither The Fund nor any of its former, current and future directors, officers, employees, volunteers, affiliates and agents (each of the foregoing, a "Fund Agent") (including each Fund Agent who participates in the planning, organization or implementation of The Fresh Air Fund Activities) shall have any responsibility for any injury to person or property, illness, loss of life or property, liability, damage, expense or other adverse event that may occur during Fresh Air Activities, other than as the direct consequence of any gross negligence or willful misconduct of The Fund or any Fund Agent.

I understand that, as a result of my executing this release, I and the other Child Parties shall be forever barred from suing or otherwise asserting a claim, demand or cause of action against The Fund and The Fund Agents to the extent provided above.

I hereby represent and warrant to The Fund that I am authorized to sign this Consent & Release Form on behalf of Child Parties and to bind them hereby.

Signature: _____ Date: _____/_____/_____

Print Name: _____

Title if child is in foster care: _____

Child's First Name _____ MI ___ Last Name _____ DOB ___-___-20__ (MONTH DAY YEAR)

Please do not cover barcode

Please read, sign and date both **PARENTAL CONSENT & RELEASE FORMS** *(pages 11 and 12).*

As the parent/guardian of the above-named child, my signature/electronic signature on Page 6 and on this page affirm that:

A) I give the following permissions to The Fresh Air Fund:

1. To use photos and/or videos of my child and his/her first name in public relations efforts, including, but not limited to print and electronic media and ads, and social media platforms. This permission extends to The Fresh Air Fund's cooperating organizations.
2. To contact third party providers (e.g. caseworkers, counselors, therapists, social workers, teachers, principals, medical physicians, or referring agencies - community based organizations, schools, churches, and hospitals) as identified in the application or evaluation consent form, if a consultation is necessary to complete the application.
3. To receive information regarding my child from their service provider if s/he has an IEP and/or is receiving services (special education, supportive services, therapy, counseling, psychiatric/psychological services, etc.).
4. To discuss my child's health history with the medical provider indicated on the medical form submitted with the application.
5. To share my child's health form and medical information directly with a third-party program (e.g. camp) if the Host Family in the Friendly Towns Program sends my child to a third-party program during his/her trip.

B) Should my child require medical treatment during his/her participation, The Fresh Air Fund and its Agents have the following permissions:

6. To communicate directly with my child's primary physician to complete the application and medical forms, if necessary.
7. To provide the Host Family with a copy of my child's health insurance card while s/he is in the Friendly Towns Program.
8. Full authority to take the actions deemed necessary to ensure my child's physical and mental health and safety, including: delivering routine and ensuring emergency health care; dispensing/administering medications; and seeking medical, dental, or vision treatment for my child, if necessary, while s/he is away.
9. To release any medical or other records necessary for treatment, referral, billing, or insurance purposes by The Fresh Air Fund to other medical personnel treating my child.
10. To obtain medical care and treatment as may be deemed necessary for the health and safety of my child by duly licensed physicians, nurses, or qualified medical personnel of any hospital, urgent care facility, or clinic.
11. To share my child's health record with duly licensed physicians, nurses, or qualified medical personnel of any hospital, urgent care facility, or clinic.
12. To share my child's health insurance information (medical and/or dental) with any provider of medical services to my child.
13. To use my child's health insurance as the primary coverage for any medical treatment s/he receives while participating in The Fresh Air Fund's program(s).
14. To receive billing and receipt information, and discharge papers once services are rendered by medical professional(s).

C) I acknowledge that:

15. I am responsible for my child's transportation to and from his/her program's departure and return site, and that s/he will only be released to an adult, aged 18 or older, named on Page 1 or 10 of this application. I acknowledge that only those participants who are 16 years of age or older may sign themselves out upon arrival at the return site with prior written parental permission.
16. I have read, or have had explained to me, information about meningococcal meningitis disease and vaccination included in the application's information packet, and if I choose not to have my child vaccinated, I confirm that I understand the risks of not having my child vaccinated.
17. My child may use non-aerosol sunscreen and bug repellant s/he has brought to Camp/Friendly Town or that Camp/Friendly Town has supplied, which is approved by the FDA for over-the-counter use to avoid overexposure to the sun. Sunscreen may be applied by camp staff or host volunteer if my child requests.
18. In addition to calls from The Fresh Air Fund's staff and volunteers, information for application completion, participation confirmation, and other updates may be sent by email, text or automated phone calls.
19. My child must comply with all program rules and standards including, but not limited to: house/cabin rules; cell phones, electronics and technology; and pool safety. His/her failure to do so may result in an early end to his/her summer experience. I understand that in the event of an early return, I will be required to pick my child up from The Fresh Air Fund's office and participate in an exit interview with my child and a Fresh Air Fund Social Worker.
20. My child's health insurance will be the primary coverage for any medical treatment s/he receives while participating in The Fresh Air Fund program, and that I may be responsible for fees for hospital, nursing, medical and surgical services that exceed the amounts covered by my child's health insurance.
21. Depending on the nature of the illness or condition, it may be necessary for my child to return home early from his/her summer experience for medical treatment.
22. Designated Fresh Air Fund staff may access my child's immunization record through the NYC Department of Health's Citywide Immunization Registry or the NYS Immunization Information System to expedite application completion if I do not submit it.

Signature: _____ Date: _____/_____/_____

Print Name: _____ Title if child is in foster care: _____

Child's First Name ___ MI Last Name _____ DOB ___ - ___ - 2 0 ___
MONTH DAY YEAR

Must be Completed by Foster Care Agency

1. **This child has been in foster care since:** _____/_____/_____
MONTH DAY YEAR
2. **This child has been in the current foster home since:** _____/_____/_____
MONTH DAY YEAR
3. **Is this child's current home in one of the five boroughs?** ☐ Yes ☐ No If no, indicate city _____
4. **This child receives services from a:** *(check all that apply)*
☐ Counselor ☐ Social Worker ☐ Case Worker
☐ Psychiatrist ☐ Psychologist ☐ Guidance Counselor
☐ Other: _____ ☐ None

If you marked a provider above, call 1-800-367-0003 to obtain The Fresh Air Fund's Evaluation Form

With whom should FAF communicate for application completion? *(Choose one)* ☐ Case Worker ☐ Foster Parent ☐ Biological Parent

Agency Name: _____

Case Worker Name: _____
Work (: _____
Cell (: _____
Email: _____

Supervisor Name: _____
Work (: _____
Cell (: _____
Email: _____

Foster Parent Name: _____
Home (: _____ Work (: _____
Cell (: _____ Email: _____

Biological Parent Name *(If applicable)*: _____
Home (: _____ Work (: _____
Cell (: _____ Email: _____

The biological parent can: Get information about the trip dates and location? ☐ **Yes** ☐ **No**
Communicate with the child during the scheduled trip? ☐ **Yes** ☐ **No**

IN CASE OF MEDICAL EMERGENCY, CONTACT:

Name: _____ Title: _____
Phone (: _____ Email: _____

Please list the individuals authorized to pick up this child (if different than those on Page 1):

	Contact name	Relationship	18 or older?	Phone number(s)
1			☐ Yes ☐ No	
2			☐ Yes ☐ No	

Must be Signed & Dated by Foster Care Agency

Signature: _____ **Date:** ___ - ___ - ____
MONTH DAY YEAR

Print Name: _____

Title: _____

Child's First Name _____ MI ___ Last Name _____ DOB: ___-___-____ (MONTH-DAY-YEAR)

Please do not cover barcode

This form MUST be completed by a Doctor or qualified Medical Personnel.
Note: All listed medications will be required for check-in.
A copy of the official immunization record is required.

Child's Doctor Information

Doctor's Full Name: _____ **Doctor's Telephone (:** _____-_____-_____

Doctor's Address: _____ **Doctor's Fax (:** _____-_____-_____

Allergies

List all known allergies and **describe reaction and authorized treatment** of the reaction in each case:

Allergen	Reaction/Symptoms	Treatment/Medication/Dosage
Food allergy: (e.g. peanuts, shellfish, berries etc.)		☐ OTC: _____ ☐ Prescription: _____ ☐ Epi Pen required ☐ No medication
Environmental allergy: (e.g. pollen, dander etc.)		☐ OTC: _____ ☐ Prescription: _____ ☐ Epi Pen required ☐ No medication
Medication allergy: (e.g. penicillin, etc.)		☐ OTC: _____ ☐ Prescription: _____ ☐ Epi Pen required ☐ No medication

Asthma Information

Does this child have asthma/RAD? ☐ Yes ☐ No

Date of last asthma-related emergency room visit: ___-___-____ (MONTH-DAY-YEAR)

If Yes: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent* ☐ Severe Persistent*

Is the child prescribed asthma medication? ☐ Yes ☐ No

If Yes, please check medication(s): ☐ Albuterol ☐ Ventolin ☐ Qvar ☐ Flovent ☐ Singulair ☐ Other: _____

Does child have an **Asthma Treatment Plan**? **☐ Yes ☐ No If Yes, please provide a copy** ***(* Action Treatment Plan REQUIRED)***

Behavioral Information

Please indicate if child has ever been diagnosed with any of the following: ☐ None ☐ ADHD ☐ Anxiety ☐ Depression

☐ Behavioral/Cognitive Disorder ☐ Other _____

If Yes and medication is prescribed, please list:

_____

Diabetes Information

Does this child have diabetes? ☐ Yes ☐ No

If Yes: ☐ Type 1 ☐ Type 2

Does this child currently take insulin? ☐ Yes ☐ No

If Yes, please attach Diabetes Treatment or Action Plan

TB Mantoux Test

Date of test: ___-___-____ (MONTH-DAY-YEAR) **Result: ☐ Positive ☐ Negative**

If Positive, chest x-ray result: _____

Does this child take TB meds? ☐ Yes ☐ No

If Yes, please list medication: _____

Since: ___-___-____ (MONTH-DAY-YEAR) **Regimen: ☐ 3 mo. ☐ 6 mo. ☐ 9 mo. ☐ Other** _____

This child is no longer contagious and can participate in a residential community ☐ Yes ☐ No

Health History

Has this child had any of the following?

☐ Sickle Cell ☐ Lyme Disease ☐ High Cholestrol
☐ Diabetes ☐ Seizure Disorder ☐ Mumps
☐ Heart Disease ☐ Rheumatic Fever ☐ Hepatitis
☐ Measles ☐ Chicken Pox
☐ German Measles ☐ Tuberculosis
☐ Congenital or Acquired Heart Disorder
☐ Speech, Hearing, or Visual Impairment
☐ Other Communicable Diseases *(indicate below)*

_____

☐ Other _____

Continued on next page. Doctor signature, stamp, and date re-

Medical 2 | **The Fresh Air Fund: Authorized Medications** | **2020 CHILD APPLICATION**

Child's First Name _____ MI ___ Last Name _____ MONTH ___ - DAY ___ - YEAR _____

Please do not cover barcode

Routine Medications

This form MUST be completed by a Doctor or qualified Medical Personnel.
Note: All listed medications will be required for check-in.

Please list *ALL* medications currently and routinely taken (including prescription, non-prescription or over-the-counter).

☐ This child **does not** take medications on a routine basis

☐ This child takes medications as indicated below

Medication name	Route	Dosage	Frequency	Diagnosis/Comments

Other Authorized Medications

The following medications are available in the camp infirmary/at hosts' homes and will be dispensed at the discretion of medical personnel or hosts, unless otherwise noted by the child's healthcare provider.

As this child's healthcare provider you authorize that (**unless otherwise noted in "Remarks"**) the medications listed below can be dispensed at the discretion of medical personnel at camp and/or a host parent in Friendly Town per dosage, schedule and route indicated on the label.

Drug Name	Indications	Remarks
Tylenol (or generic acetaminophen)	Pain or fever	
Ibuprofen	Pain or fever	
Robitussin/Jr. (or generic)	Cough	
Chloraseptic (or generic)	Sore throat	
Children's Mylanta (or generic antacid)	Upset stomach	
Milk of Magnesia (or generic laxative)	Constipation	
Mucinex/Mucinex Jr. (or generic)	Congestion	
Visine (or generic)	Eye redness / irritation	
Sudafed (or generic)	Nasal congestion / Eustachian tube congestion	
Claritin (or generic)	Nasal congestion / Seasonal allergy symptoms	
Benadryl (or generic diphenhydramine)	Allergic reactions (hives, insect bites)	
Antibiotic Ointment	Superficial cuts / abrasions	
Hydrocortisone Cream	Allergic reactions (contact dermatitis, insect bites)	
Calamine Lotion (or generic)	Allergic reactions (hives, insect bites)	

Health Examination/Findings

Weight: _____ Height: _____ BP: _____

This child is able to participate in a physically active program, including swimming ☐ Yes ☐ No

Does this child have any restrictions, physical limitations, psychological, developmental or learning delays?

☐ **None (within normal limits)**

☐ **Yes - please fill out the rest of this section:**

☐ **Physical** ☐ **Cognitive** ☐ **Behavior/Social/Emotional** ☐ **Communication/Language** ☐ **Other**

Please explain:_____

Doctor's Signature & Stamp

I certify that the medical history of this child is correct, and that he or she has medical clearance to engage in all activities, except for those noted on this form. In addition I authorize that (unless otherwise noted in "**Remarks"** above) medications listed under Other Authorized Medications section can be dispensed at the discretion of medical personnel at camp and/or a host parent in Friendly Town per dosage, schedule and route indicated on the label.

Doctor's Stamp

Doctor's Signature: _____ **Date of Examination:** MONTH ___ - DAY ___ - YEAR _____

Date of Exam must be after June 1, 2019