


Summer Camp Registration

What you will need to turn in before starting camp:

1. Registration Form
2. Birth Certificate
3. Physical and Immunization Records
4. Tuition Contract
5. Signed DCFS Form
6. $50 Registration Fee

Communication:

Remind App: Summer camp will use an app called REMIND to communicate with our parents and guardians. Once you have registered with us, we will add you to the app. This is a fast and easy way to communicate information to all families at once. You can also message us as well through this app. Any important information will come via text. Please download it.

S.O.T.H. Cell Phone: We have a phone that is with us at all times. Text or call at any time during camp hours
@ 815-276-6829

Facebook: Check us out during the day! See what fun we are up to.

Search: shepherdofhillsBandA

2024
Shepherd of the Hills
Summer Camp

Date Starting_____ Exit Date_____

Child's Name: _____ Age/Grade_____ D.O.B_____
Address_____ Home #_____
City _____ Zip_____ Male/Female (circle)

Parents/Guardians
Name: _____ Relationship_____
Address: _____ Cell #_____
Occupation_____ Work #_____
Email_____

Name: _____ Relationship_____
Address: _____ Cell #_____
Occupation_____ Work #_____
Email_____

	TIME		**TIME**	**DAYS (circle)**
Summer	***Drop off_____a.m.***	**-**	***Pick up _____p.m.***	***M T W TH F***

Registration Fee: _____ **Weekly Tuition:_____**

Numbers For emergency Contact & Non-Emergency Release
In case of an emergency, and we are unable to contact a parent/guardian, please provide information on additional adults that we may contact. Also, please list people that you give permission to our staff to release your child to.
Name_____ Relationship_____ #_____
Name_____ Relationship_____ #_____
Name_____ Relationship_____ #_____

Signature of Understanding
After filling out this form and reading the "PARENT HANDBOOK", I understand all information given, that all forms are correct, and I agree to follow all terms of the B&A School Care and Summer Camp. **Initials**_____

Summer Camp
*Summer Camp includes a number of mandatory activities that will take place throughout the summer. Parents are responsible for the extra cost for these trips and activities when necessary. The summer activities may include, but are not limited to: Vacation Bible School, Knox Pool, Roller Rink, Bus Field Trips, and Walking Field Trips. We will walk to all local destinations. **Initials**_____

Medical Conditions

Please let the director or teacher know of any special allergies or medical conditions your child may have. This will assist us in being better prepared to handle any emergencies that might arise.

1.Are there any special family circumstances we should be aware of? i.e. Divorce, death, adoption, just moved etc..... _____

_____

2.Are there any special characteristics we should be aware of? i.e. Physical disabilities, learning disabilities, difficulties in hearing or speech, special fears etc..... _____

_____

3.Does your child have any allergies? If yes, what are they? _____

_____

4.Does your child take medication on a regular basis? _____

_____

5. Any other info that might be helpful to us? _____

_____

Consent Forms

The consent forms listed below are to be filled out completely, signed, and dated. These are designed to assist us in giving your child the best care possible. If you have any questions, please contact Ms. Ashley.

Consent Form 1

I, _____, give my consent to the staff members of the Shepherd of the Hills B&A School Care and Summer Camp Programs to call for emergency medical treatment for my child, _____, if necessary. It is understood that a conscientious effort will be made to locate me and that I, the parent/guardian, will pay any expenses that may occur.

_____ _____

Signature of Parent/Guardian Date

Consent Form 2

I, _____, give my consent to the staff members of the Shepherd of the Hills B&A School Care and Summer Camp Programs, who are trained in first-aid, CPR and AED to administer treatment to my child, _____, should such an emergency arise.

_____ _____

Signature of Parent/Guardian Date

Child Doctor to be called in case of an emergency

Doctor's Name_____ #_____

Address_____ City_____ Zip_____

Comments_____

Photographs

I agree that my child's picture, not name, may be used in press releases and for promotion of the S.O.T.H. B&A School Care and Summer Camp Programs.

_____ _____

Signature of Parent/Guardian Date

***Shepherd of the Hills reserves the right to dis-enroll any child for non-payment or behavioral issues.**

Initial._____

SHEPHERD OF THE HILLS
BEFORE AND AFTER-SCHOOL CARE
SUMMER CAMP PROGRAM

Welcome!! The purpose of the Shepherd of the Hills Before and After School Care and Summer Camp program is to provide a quality environment which displays intellectual, social, creative, spiritual, and physical skills which are necessary for the personal growth of the child.

SUMMER CAMP HOURS

6 a.m. – 6 p.m. – Summer hours,
Days off and Early Dismissals

REGISTRATION AND TUITION RATES

The registration fee to enroll is $50.00. **This is an annual fee**

Summer Camp tuition:
6 a.m. – 6 p.m.....$220 wk. or $50 day

***TUITION IS DUE EVERY MONDAY. WE DO NOT TAKE CREDIT CARDS. CHECK CAN BE MADE PAYABLE TO SHEPHERD OF THE HILLS (SOTH) AND/OR CASH ONLY.**

***FULL WEEKLY TUITION IS DUE REGARDLESS OF THE CHILD'S ATTENDANCE, SICK, VACATION OR HOLIDAYS.**

***VACATION WEEKS (MONDAY – FRIDAY) MAY BE TAKEN AT ONE HALF TUTION RATE WITH PRIOR NOTICE.**

***IF YOU ARE 2 WEEKS BEHIND ON TUITION PAYMENTS YOUR CHILD WILL NOT BE ABLE TO ATTEND THE PROGRAM UNTIL THE BALANCE IS PAID IN FULL.**

***IF LATE PAYMENTS CONTINUE YOU WILL HAVE TO START PAYING A WEEK IN ADVANCE.**

***THERE IS A DISCOUNT FOR FAMILIES WITH MULTIPLE CHILDREN. 2ND CHILD IS 10% OFF WEEKLY TUITION.**

Signature_____ **Date:** _____

Please sign the form below and turn in with your registration paper work.

You can print a copy of the DCFS summery of Licensing on S.O.T.H. web site or get a copy from the director.

Thank you

Ashley Metcalf

CFS 581
Rev. 12/2000

State of Illinois
Illinois Department of Children and Family Services

VERIFICATION OF RECEIPT

I/WE, _____
Please Print Name(s)

parent(s) of _____, hereby certify that I/we have
Name(s) of Child(ren)

received a copy of a summary of licensing standards printed by the Illinois Department of Children and Family Services.

_____ _____
Signature of Parent Date

_____ _____
Signature of Parent Date

THIS COMPLETED FORM IS TO BE PLACED IN EACH CHILD'S FILE AT THE DAY CARE FACILITY.

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 11/2013

Illinois Department of DCFS Children & Family Services

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian	Telephone # Home		Work

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric DT (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																						
Age/ Grade																						
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L		
Vision																						
Hearing																						

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

Student's Name (Last / First / Middle)	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID #

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)

MEDICATION (List all prescribed or taken on a regular basis.)

Diagnosis of asthma? Child wakes during the night	Yes Yes	No No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ • Bridge ☐ • Plate Other			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** Date			
Bone/Joint problem/injury/scoliosis?	Yes	No					

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed** ☐ **Test performed** ☐
Skin Test: Date Read / / **Result: Positive** ☐ **Negative** ☐ **mm** _____
Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value** _____

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified,please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS** (for one year) Yes ☐ No ☐ Limited ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)