



Camp Gan Israel

Kiryat Gan Israel - Parksville, NY 12768

New York Office: 770 Eastern Parkway ❖ Brooklyn, NY 11213 ❖ (718) 774-4805 ❖ Fax: (718) 756-3531

STAFF APPLICATION FORM

Date ____/____/____
Month Day

Applying for - Counselor Learning Teacher Life Guard Waiter Other _____

PERSONAL INFORMATION
Last Name _____ First Name _____ Age _____ (On first day of camp)
Street Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ - _____ Home Fax (____) _____ - _____ Email _____
Civil Birthdate ____/____/____ Jewish _____ Hebrew Name _____ S.S. # _____ Month Day Year
PARENT INFORMATION
Father's Name _____ Occupation _____ S.S. # _____
Business Address _____ Business Phone (____) _____ - _____
Mother's Name _____ Occupation _____ S.S. # _____
YESHIVA INFORMATION
Yeshiva Currently Attending _____ Current Shiur/Class _____
Street Address _____ City _____ State _____ Zip _____
Yeshiva Phone. (to best reach you) (____) _____ - _____ Yeshiva Fax (to reach you) (____) _____ - _____
Magid Shiur (Teacher) _____ Phone Num.(____) _____ - _____
EDUCATIONAL BACKGROUND
Please list all the yeshivas you attended in the past, and when.
Yeshiva _____ Year _____ Yeshiva _____ Year _____
Yeshiva _____ Year _____ Yeshiva _____ Year _____
CAMP HISTORY
Please list all the camps you attended as a camper and when.
Camp _____ Years ____/____/____ Camp _____ Years ____/____/____
Camp _____ Years ____/____/____ Camp _____ Years ____/____/____

Please list all the camps you attended as a **staff member** and when.

Camp _____ Position _____ Year _____ Head Counselor _____
(the one who hired you)

Camp _____ Position _____ Year _____ Head Counselor _____
(the one who hired you)

Camp _____ Position _____ Year _____ Head Counselor _____
(the one who hired you)

Other community work you participated in the past.

Institution _____ Employer _____ Year _____
(person you worked directly under)

Institution _____ Employer _____ Year _____
(person you worked directly under)

PART II EVALUATION

As a staff member what do you consider your main responsibilities and objective? _____

What do you feel you can offer the children spiritually? _____

Do you consider yourself sensitive to the children's needs, both emotional and physical? explain. _____

Why did you choose to spend your summer in camp, and why this one? _____

What special skills and talents do you possess _____

What other child care experience have you had? _____

Have you ever been convicted of any crime? If yes please state. _____

REFERENCES

Please list two references whom we can contact to discuss the possibility of your employment.

Name _____ Position _____ Daytime Phone (_____) _____ - _____

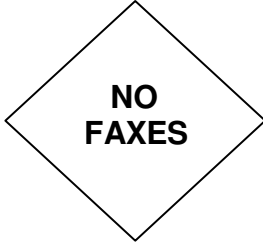
Name _____ Position _____ Daytime Phone (_____) _____ - _____

For Office Use Only

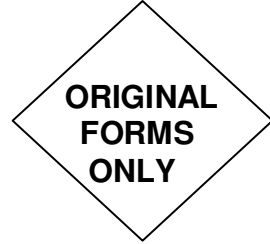
Approved Rejected

Director _____ Asst. Director _____ Date _____

Camp Gan Israel
Kiryat Gan Israel, NY 12768
Tel: (718) 774 4805 / (845) 292 9665



Confidential Medical and Consent Form



Please return this form to:
Camp Gan Israel, 770 Eastern Pkwy, Suite 209
Brooklyn, NY 11213

Camper's name: _____
Home address: _____
City: _____ State: _____
Country: _____ Zip/postal code: _____
Date of Birth: _____ Present age: _____

The above camper will be attending the following trips: First Second

Home phone #: (____) _____ Summer Phone #: (____) _____
Father's business #: (____) _____ Name of bungalow colony: _____
Mother's business # (____) _____ In emergency, call: Name: _____
Cell phone # (____) _____ Phone #: _____

If your child has a chronic or acute medical condition, it is imperative that the camp be notified. To speak to the camp medical staff regarding your child's confidential medical information, please call them by June 1st at the number at the top of this form. All information will be held confidential.

MEDICAL & PRESCRIPTION DRUG INSURANCE INFORMATION

Please make a copy of your medical insurance card and paste it in the left box below. If you have separate prescription drug coverage, make a copy of that card and paste it in the right box below. ***If no cards are attached, you will be billed for your child's medical insurance and prescription drugs at regular rates.***

Paste a copy of the medical insurance card here.
Please remember to complete the insurance information section on page 2
 I do not have medical insurance

Paste a copy of the back of your medical insurance card here.

Paste a copy of the front of your prescription drug card here.
 My medical & drug coverage is the same
 I do not have drug coverage

Turn over →

Camp Gan Israel
Kiryat Gan Israel, NY 12768
Tel: (718) 774 4805 / (845) 292 9665
TO BE COMPLETED BY PARENTS

Insurance information:

Company name: _____ Policy in name of: _____

Relationship: _____ Group name and number: _____ ID number: _____

Other/secondary insurance carrier and identification information, if different from above: _____

To assist us in the care of your child, please detail any special circumstances or conditions that our medical or counseling staff should be aware of (e.g. frequent colds, headaches, stomachaches, diarrhea/constipation, vomiting, bedwetting, sensitivity to insect bites, homesickness, nightmares, anxiety reactions etc), and what you would recommend as treatment:

Important note: The camp office **must** be notified if your child is exposed to any communicable disease during the three weeks prior to camp attendance.

DEPARTMENT F HEALTH REGULATIONS REQUIRE THE FOLLOWING AUTHORIZATIONS IF YOUR CHILD ATTENDS A SLEEP-AWAY CAMP:

PARENTS' AUTHORIZATION TO TREAT & MENINGITIS VACCINATION RESPONSE
SIGNATURE REQUIRED TO ATTEND CAMP

1. This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted to me and the examining physician.

2. I hereby give permission to the physician selected by the camp director to order x-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, order injections and/or anesthesia and/or surgery for my child as named above.

3. I have read the camp letter describing Meningitis, its transmission, the benefits, risks and effectiveness of immunization, availability and cost. (Please check one box and sign below)

My child has had the meningococcal meningitis immunization (Menomune) within the past 10 years. Date received:

I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease.

Parent's signature

Witness' signature

Date

**AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR
TEMPORARILY SEPARATED FROM HIS/HER PARENTS**

I/We, the undersigned parents of _____, a minor, do hereby authorize Camp Gan Israel, and/or Rabbi Joseph Y Futerfas, Director, as our agent(s) to consent to any diagnostic procedure or medical care for said child which is deemed advisable by, and is rendered under the general or special supervision of any licensed physician or surgeon at Catskill Regional Medical Center (formally Community General Hospital of Sullivan County) or at any other accredited hospital, when such diagnosis or treatment is rendered at said hospital.

It is understood that this authorization is given in advance of any specific need for treatment, but is given to provide authority on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his best judgment may deem advisable.

This authorization shall remain effective until August 25, 2008, unless sooner revoked in writing and delivered to said agent(s).

Parent(s) signature: _____ Date: _____ Phone #: _____

Witness signature: _____ Date: _____

Permanent address: _____

Temporary address/name of bungalow colony: _____

TO BE COMPLETED BY EXAMINING PHYSICIAN

Camper's name: _____
 Home address: _____ City: _____ State: _____
 Zip/postal code: _____ Country: _____
 Weight: _____ Height: _____

Immunization History:

Please record month and year of basic immunizations and most recent booster. Please do not call our office for this information. We do not have it on his file from previous years.

Immunization	Date basic series completed	Most recent booster.
DPT or DT		
Tetanus		
Oral Polio		
MMR		
HIB		
Hepatitis A		
Hepatitis B		
Varicella		

Allergies:	Yes	No	Comments
Penicillin			
Sulfa			
Cephalosporins			
Other medication			
Food allergies			
List foods your child is allergic to.			
Bees/insect bites			

Has your child ever had an anaphylactic reaction?

Yes No,
 IF YES, YOU MUST SEND AN EPI-PEN ALONG WITH YOUR CHILD. (CHECK THAT IT HAS NOT EXPIRED OR YOU WILL BILLED FOR ONE ONCE IN CAMP.)

Medical History: Indicate date of illness

Chicken Pox	_____	
Measles	_____	
German measles	_____	
Mumps	_____	
Hepatitis	_____	
Pneumonia	_____	
<input type="checkbox"/> Positive PPD	Date: _____	
CXR	Date: _____	
Treatment protocol	_____	
Indicate if being treated for the following:		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> seizures	<input type="checkbox"/> seasonal allergies
<input type="checkbox"/> Rheumatic fever		
Frequent <input type="checkbox"/> Ear infections	<input type="checkbox"/> Strep throat	
<input type="checkbox"/> Asthma	(If your child is being treated for asthma, please send along the tubing for the nebulizer as well as all inhalers being used AND MAKE SURE THAT THE NURSE IS NOTIFIED BEFORE CAMP BEGINS.)	

Individualized Orders

Standard over-the counter/PRN Medications
 (Available in infirmary/First Aid Kit) To be administered at the discretion of the RN unless

Drug or generic equivalent	Route	Dosage	Schedule	Contra-indicated	Comments
Tylenol	PO	Per label instructions by age/weight	Q 3-4 hr prn for discomfort or elevated temp		
Ibuprofen	PO	Per label instructions by age/weight	Q 6hr prn for discomfort or elevated temp		
Robitussin	PO	Per label instructions by age/weight	Q 4-6 prn for cough		
PeptoBismol	PO	Per label instructions by age/weight	Q 30 min to 1 hr prn for diarrhea (not >8 doses/24 hr)		
Mylanta	PO	Per label instructions by age/weight	TID-QID prn for gastric upset		
Dramamine	PO	Per label instructions by age/weight	½ hr b4 embarkation, then q 6-8 hr prn for motion sickness		
Dimetapp	PO	Per label instructions by age/weight	Q 6-8 hr for nasal congestion/drainage		
Benadryl	PO	Per label instructions by age/weight	Q 6hr prn for allergic reaction		
Sudafed	PO	Per label instructions by age/weight	Q 6-8 hr for nasal congestion/drainage		
Tums	PO	Per label instructions by age/weight	Q 30 min prn for gastric upset/heartburn		
NaphconA		Per label instructions by age/weight	1-2 gtts affected eye q 4-6 hr itching/burning		
Milk of Magnesia	PO	Per label instructions by age/weight	BID-TID prn for gastric upset/constipation		
Ear Drops		Per label instructions by age/weight	Apply to affected area as indicated		
Cortisone Ointment		Per label instructions by age/weight	Apply to affected area as indicated		
Antifungal Ointment Spray		Per label instructions by age/weight	Apply to affected area as indicated		

Check here if doctor is enclosing a separate signed form regarding the above information.

Dear Doctor, (signature required)

List dates & description of operations, serious injuries or fractures: _____

Chronic or recurrent illness and suggested treatment: _____

SPECIAL RESTRICTIONS:

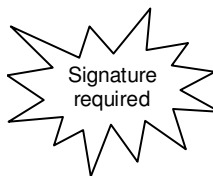
Diet: _____

Swimming: _____

Strenuous activity: _____

Other: _____

To the best of my knowledge the information stated above is true and accurate and it is my opinion that the camper named above is physically able to engage in all camp activities, except as noted above.



Physician's signature: _____ Date: _____

Physician's name: _____ Emergency phone #: _____

Address: _____

Parents, please note:

- ❖ If your child comes to camp with “over-the-counter” medications, try to make sure that they have enough for the entire trip or summer. Some of the more usual over-the-counter medications are not readily available at upstate pharmacies. These medications must be kept in the infirmary.
- ❖ If your child is coming to camp with year-round prescription medication, we must have a note from your doctor detailing the medication prescribed, the dosage, the time and frequency that it should be taken and the reasons for taking the medication. No **unlabeled medication** will be dispensed. Verbal information about medication is insufficient. All medications must be kept in the infirmary.
- ❖ At the suggestion of our doctors, allergy medications/shots should be started about a month prior to camp to facilitate relief during the summer. We will be glad to continue the treatments.
- ❖ To avoid any possible embarrassment and discomfort of your child, please be sure to check him thoroughly for the presence of lice prior to sending him to camp. (it is in your child's best interest to address this problem at home, even at the expense of missing the first few days of camp.)

Your medical form will be returned if:

- **Consent form is not signed in both places. (page 2)**
- **Immunization dates are not listed. (page 3)**
- **Individualized orders section is not complete. (page 3)**
- **Doctor's name and phone number are not listed. (see above)**
- **It is not signed by your doctor. (see above)**
- **Any section, or part thereof, is omitted that can affect the safe treatment of your child.**

Return this form no later than June 1st to:
Camp Gan Isreal, 770 Eastern Pkwy, Suite 209, Brooklyn 11213

COMPLETE ONLY ONE APPLICATION FOR YOUR HOUSEHOLD

FAMILY APPLICATION FOR FREE AND REDUCED PRICE SCHOOL MEALS/MILK

To apply for free and reduced price meals for your children, read the instructions on the back, complete only one form per household, sign your name and return it to _____. Call _____ if you need help. For additional names, list on a sheet of paper.

1. CHILDREN IN SCHOOL: (Complete a **separate** application for each foster child.)

Children's Names (Last, First, MI)	Grade/Teacher	School

2. FOSTER CHILD: If the above named child is the legal responsibility of a welfare agency or court, check this box.
List the child's personal use income: _____ (Write "0" if the child has no personal use income.) Skip to Part 5.

3. HOUSEHOLDS GETTING FOOD STAMPS OR TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF): Complete this section and sign the application in Part 5 **OR** submit a Direct Certification letter from the Office of Temporary and Disability Assistance or Food Distribution Program on Indian Reservations (FDPIR). Complete a separate application for children with a different case number or no case number. Write your case number as provided on your benefit letter, **not the number on your benefit card.**
Food Stamp Case #: _____ TANF/FDPIR Case #: _____

4. HOUSEHOLD MEMBERS & TOTAL HOUSEHOLD INCOME: If you did not give a food stamp or TANF case number, or submit a Direct Certification letter, complete this part and all of part 5.

Show how often each amount is received. See Examples	CURRENT INCOME/PAY PERIOD Examples: \$100/weekly, \$100/bi-weekly, \$100/2x per month, \$100/monthly If pay period is not noted, the reviewing official will process the reported income amount as received WEEKLY.			
List the names of everyone in your household	Earnings From Work Before deductions	Child Support, Alimony, Etc.	Payments from Pension or Retirement	Other Income
	Amount / How Often	Amount / How Often	Amount / How Often	Amount / How Often
1. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
6. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
7. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

5. SIGNATURE: An adult household member MUST sign the application before it can be approved.
I certify that all of the information is true and that all income is reported. I understand that the information is being given for the school to receive federal funds; that school officials may verify the information and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and federal laws, and my children may lose meal benefits.

SIGNATURE: _____ **DATE:** _____ **SOCIAL SECURITY #** _____ - _____ - _____

Home Telephone _____ Work Telephone _____ Mailing Address _____ Zip Code _____

SOCIAL SECURITY NUMBER: If Part 4 is completed, the adult who signs the application **must** provide his/her Social Security number.

DO NOT WRITE BELOW THIS LINE - FOR SCHOOL USE ONLY

ANNUAL INCOME CONVERSION (ONLY CONVERT WHEN MULTIPLE FREQUENCIES ARE REPORTED ON APPLICATIONS):
WEEKLY X 52; EVERY 2 WEEKS X 26; TWICE A MONTH X 24; MONTHLY X 12

FOOD STAMP, TANF, Foster Child
 INCOME HOUSEHOLD: Total Household Income/Frequency: _____ / _____ Household Size: _____
 Application APPROVED for: Free Meals Reduced Price Meals
 Temporary Free (expires in 45 days) ___/___/___ Application DENIED
 Date Notice Sent: _____ Signature of Reviewing Official: _____ Date: _____

APPLICATION INSTRUCTIONS

To apply for free and reduced price meals, submit a Direct Certification letter received from the Office of Temporary and Disability Assistance OR complete only one application for your household using the instructions.. Sign the application and return the application to _____ . Please complete a separate application for **each** foster child. Call the school if you need help: _____ . Ensure that all information is provided. Failure to do so may result in denial of benefits for your child or unnecessary delay in approving your application.

PART 1 ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE APPLICATION FOR YOUR HOUSEHOLD.

- (1) Print the names of the children for whom you are applying on one application. (For Foster Children, see Part 2)
 - (2) List their grade and school.
-

PART 2 HOUSEHOLDS WITH A FOSTER CHILD SHOULD COMPLETE THIS PART AND SIGN PART 5. A foster child is the legal responsibility of a welfare agency or court. A separate application must be completed for each foster child.

- (1) List the foster child's monthly "personal use" income. ("Personal Use" income is money given by the welfare office identified by category for the child's personal use, such as an allowance, and all other money the child gets, such as money from his/her family or money from the child's employment.) Write "0" if the foster child does not get "personal use" income. **SKIP PART 4.** Do not list any other children, household members or income, or a social security number.
 - (2) A foster parent or other official representing the child must sign the application in PART 5.
-

PART 3 HOUSEHOLDS GETTING FOOD STAMPS, TANF OR FDPIR SHOULD COMPLETE THIS PART AND SIGN PART 5. COMPLETE A SEPARATE APPLICATION FOR A CHILD/CHILDREN WITH A DIFFERENT CASE NUMBER.

- (1) List a current Food Stamp case number, TANF or FDPIR (Food Distribution Program on Indian Reservations) number. Do not use the number on your benefit card. The case number is provided on your benefit letter.
 - (2) An adult household member must sign the application in PART 5. **SKIP PART 4.** Do not list names of household members or income if you list a food stamp case number, TANF or FDPIR number.
-

PARTS 4 & 5 ALL OTHER HOUSEHOLDS MUST COMPLETE THESE PARTS AND ALL OF PART 5.

- (1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are applying for, all other children, your spouse, grandparents, and other related and unrelated people in your household. Use another piece of paper if you need more space.
 - (2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, bi-weekly, monthly, 2 x per month.** Changes in income during the school year no longer need to be reported.
 - (3) The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should **not** be considered as income for this program.
 - (4) The application must include the social security number of the adult who signs **PART 5** if Part 4 is completed. If the adult does not have a social security number, write "none". If you listed a food stamp, TANF or FDPIR number, or if you are applying for a foster child, a social security number is not needed.
-

OTHER BENEFITS: Your child may be eligible for benefits such as Medicaid or Children's Health Insurance Program (CHIP). In order to determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

PRIVACY ACT STATEMENT

Section 9 of the National School Lunch Act requires that unless your children's food stamp, TANF or FDPIR case number is provided, you must include the social security number of the adult household member signing the application, or indicate that the household member does not have a social security number. If a social security number is not given or an indication is not made that the signer does not have such a number, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits and investigations and may include contacting employers to determine income, contacting a food stamp or welfare office to determine current certification for receipt of food stamps or other benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by household members to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

DISCRIMINATION COMPLAINTS

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, gender, or disability. To file a complaint, write to *USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410* or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.