☐ Friendly Town ☐ Camp

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For office use only → ☐ Auth ☐ Ent ☐ Proof

1) CHILD INFORMATION

Has your child attended a Fresh Air Fund program before? ☐ Yes ☐ No

Child's last name: _____

Child's first name: _____ **M.I.:** ____

Date of birth: ____ (Month) – ____ (Day) – ____ (Year) Age: ____ Gender: ☐ Male ☐ Female

Child's address: _____ **Apt #:** ____

City: _____ **Borough:** _____ **Zip:** ____

School: _____ **School borough:** _____ Current grade: ____

CHILD'S LAST NAME: _____ FIRST: _____

2) FAMILY INFORMATION

➔ Please write **first name then last name** in the spaces below.

Parent / Guardian 1: _____

Home ✆: ___–___–____ Cell ✆: ___-___-____ Work ✆: ___-___-____

Relationship to child: _____ ☐ **Authorized to pick up child** ☐ Currently living with child

Primary email address: _____ Fax ✆: ___-___-____

Parent / Guardian 2: _____

Home ✆: ___–___–____ Cell ✆: ___-___-____ Work ✆: ___-___-____

Relationship to child: _____ ☐ **Authorized to pick up child** ☐ Currently living with child

Is your child currently in foster care? ☐ No ☐ Yes → In your foster home since: ___/___/___ (Month / Day / Year)

Foster care agency name: _____ Caseworker's ✆: ___-___-____

3) EMERGENCY CONTACTS

➔ **Please note:** If we are unable to reach you, we will call your child's emergency contacts in the order below. **These contacts must be people who are authorized to pick up your child.**

#	**Contact name** (**not** mother, father or guardian)	**Relationship**	**Phone numbers** (e.g. cell, home, work)
1			___-___-____ / ___-___-____
2			___-___-____ / ___-___-____
3			___-___-____ / ___-___-____

4) PARENT / GUARDIAN SIGNATURE

As the parent or legal guardian of this child I consent to have my child attend The Fresh Air Fund's ("The Fund") programs and participate in all related activities, including those described and shown in The Fund's brochures. I give permission to The Fund to:

1. use pictures or video in which my child might appear to help publicize The Fund and/or cooperating organizations;
2. call the counselor, therapist or social worker listed above and/or on Page 4, if a consultation is necessary;
3. provide routine and emergency health care, dispense medications, and seek medical or dental treatment for my child, if necessary, while he or she is away; I consent to the release of any medical or other records necessary for treatment, referral, billing, or insurance purposes to The Fund or other medical personnel treating my child;
4. use the proceeds of whatever hospitalization or medical coverage my child may have in case of illness or accident.

If my child is going to camp, I confirm that I have read, or have had explained to me, the enclosed information about meningitis vaccination. If I choose not to have my child vaccinated, I confirm that I understand the risks of not receiving the vaccine.

REQUIRED **Signature of parent or legal guardian:** _____ **Date:** ___/___/___ (Month / Day / Year)

Agency use only → Agency: _____ Reviewed for completion by: _____

SECTIONS 5-12 MUST BE COMPLETED BY THE CHILD'S DOCTOR

Please do not cover barcode →

Child's last name: _____ **Child's first name:** _____ MI:_____

Child's date of birth: _____/_____/_____ Gender: ☐ M ☐ F
Month Day Year

➔ **DOCTOR COMPLETES PAGES 2 & 3**

5) CHILD'S DOCTOR INFORMATION

Doctor's full name: _____

Doctor's address: _____

Doctor's telephone (: _____-_____-_____ **Doctor's fax (:** _____-_____-_____

6) ALLERGIES

List all known allergies that this child has and **describe reaction and authorized management** of the reaction in each case*:*

Medication allergies (e.g. penicillin): _____

Environmental allergies (e.g. pollen): _____

Food allergies (e.g. peanuts): _____

7) ASTHMA INFORMATION

Does this child have asthma/RAD? ☐ No ☐ Yes – please fill out the rest of this section

How often does this child have attacks? _____

Last date in emergency room: _____/_____/_____
Month Day Year

8) IMMUNIZATION & HEALTH HISTORY

Please give all dates of immunization for: *(Or attach photocopy of official record)*

Vaccine	**Dates:** Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	
MMR	_____	_____				
or Measles	_____	_____	*or Mumps*	_____	_____	
or Rubella	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Varicella (chicken pox)	_____	_____				
Meningococcal meningitis	_____	_____				

Which of the following diseases has this child had?

☐ Measles
☐ Chicken pox
☐ German measles
☐ Mumps
☐ Hepatitis
☐ Tuberculosis
☐ Rheumatic fever

TB Mantoux Test

Date of test: ____ / ____ / ____
Result: ☐ Negative ☐ Positive
If positive, chest x-ray result: _____
Is child on TB meds? ☐ No ☐ Yes

Has this child been diagnosed with ADD or ADHD?

☐ No ☐ Yes

Which of the following has this child had a history of?

☐ Sickle Cell ☐ Lyme Disease ☐ Diabetes
☐ Seizure Disorder ☐ Heart Disease

CONTINUED (WITH DOCTOR'S SIGNATURE) ON PAGE 3 ➥

SECTIONS 5-12 MUST BE COMPLETED BY THE CHILD'S DOCTOR

Please do not cover barcode →

Child's last name: _____ **Child's first name:** _____ MI:____

Child's date of birth: ____/____/____ Gender: ☐ M ☐ F
Month Day Year

↩ CONTINUED FROM OTHER SIDE

9) ROUTINE MEDICATIONS → One of the following must be checked

☐ This child takes NO medications on a routine basis.

OR Please list ALL medications taken routinely (including over-the counter or nonprescription drugs).

☐ This child routinely takes medications as follows:

Medication name	Route	Dose	Frequency	Diagnosis

PARENTS: Please make sure your child brings all listed medications to the bus station and enough to last the entire trip. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

10) OTHER AUTHORIZED MEDICATIONS

The following medications are available in the camp infirmary or first aid station and will be dispensed at the discretion of an RN, if approval is indicated by the camper's healthcare provider. As this child's doctor, you should check (☑) *Yes* or *No* beside **each and every** medication listed below to indicate whether or not we can dispense the drug when necessary. *For all medications, the dosage, schedule and route will be as per the label instructions and – for ingested medications – by age and/or weight.*

Drug Name	Indications	Can be used?	Comments
Tylenol (or generic)	Pain or fever	☐ Yes ☐ No	
Ibuprofen	Pain or fever	☐ Yes ☐ No	
Robitussin (or generic)	Cough	☐ Yes ☐ No	
Chloraseptic (or generic)	Sore throat	☐ Yes ☐ No	
Children's Pepto-Bismol (or generic)	Upset stomach, diarrhea	☐ Yes ☐ No	
Children's Mylanta (or generic)	Upset stomach	☐ Yes ☐ No	
Visine (or generic)	Eye redness / irritation	☐ Yes ☐ No	
Sudafed (or generic)	Nasal congestion / Eustachian tube congestion	☐ Yes ☐ No	
Claritin (or generic)	Nasal congestion / Seasonal allergy symptoms	☐ Yes ☐ No	
Benadryl (or generic)	Allergic reactions (hives, insect bites)	☐ Yes ☐ No	
Antibiotic Ointment	Superficial cuts / abrasions	☐ Yes ☐ No	
Hydrocortisone Cream	Allergic reactions (contact dermatitis, insect bites)	☐ Yes ☐ No	
Calamine Lotion (or generic)	Allergic reactions (hives, insect bites)	☐ Yes ☐ No	

11) HEALTH EXAMINATION

BP: _____ Weight: _____ Height: _____ Observations or unsatisfactory findings: _____

REQUIRED In my opinion, this child ☐ **IS** / ☐ **IS NOT** able to participate in a physically active program, including swimming.

Restrictions are as follows: _____

12) DOCTOR'S SIGNATURE

I certify that the medical history and background of this child on pages 4 & 5 is correct, and that he or she has medical clearance to engage in all activities, except the ones noted on this form.

REQUIRED

Signature: _____

REQUIRED

Date of examination: ____/____/____
Month Day Year

REQUIRED

Doctor's stamp

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Child's last name: _____ **Child's first name:** _____ MI:____

13) QUESTIONS ABOUT YOUR CHILD

REQUIRED

Does your child receive any counseling in or out of school?

☐ No ☐ **Yes** → **Please pick up an evaluation packet from your local agency or call us at 1-800-367-0003.**

Counselor, therapist or social worker's name: _____ Telephone (: _____-_____-_____

REQUIRED

Is your child in special education?

☐ No ☐ **Yes** → **Please pick up an evaluation packet from your local agency or call us at 1-800-367-0003.**

Type of special education: _____

Has/does your child:	**YES**	**NO**		**YES**	**NO**
1. Had a recent injury, illness or infectious disease?	☐	☐	9. Ever been diagnosed with a heart murmur?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐	10. Ever had seizures?	☐	☐
3. Ever been hospitalized?	☐	☐	11. Have skin problems (e.g. itching, acne, eczema)?	☐	☐
4. Ever had surgery?	☐	☐	12. Ever had problems with diarrhea/constipation?	☐	☐
5. Have frequent headaches?	☐	☐	13. Ever had an eating disorder?	☐	☐
6. Ever had a head injury?	☐	☐	14. Wear glasses, contacts or protective eye wear?	☐	☐
7. Ever been knocked unconscious?	☐	☐	15. If female, has she begun to menstruate?	☐	☐
8. Ever had frequent ear infections?	☐	☐	If not, does she know about the menstrual cycle?	☐	☐

Please explain any 'yes' answers, noting the number(s) of the question(s):

_____

_____

_____

14) HOUSEHOLD INFORMATION

Do you receive any public assistance for your child? ☐ No ☐ Yes

Primary language spoken in your household: ☐ English ☐ Spanish ☐ Chinese ☐ Other: _____

Number of brothers: _____ Number of sisters: _____

Are there any other children in your household who are applying for or have attended a Fresh Air Fund program?
This will help us keep their files together. Please tell us their names, ages, and how they are related (brother/sister/cousin etc.).

Child's Name	**Age**	**Relationship**	**Child's Name**	**Age**	**Relationship**

15) CHILD'S HEALTH INSURANCE

Does your child have Medicaid?

☐ Yes → If yes: Benefit ID #: _____ *This should read 2 letters, 5 numbers, and 1 letter* Sequence #: _____ *Found in the lower right corner of the card*

☐ No → If no:
- Medical plan name: _____ ID or policy #: _____
- Insurance provider's (: _____-_____-_____

➔ **IMPORTANT: Please include a photocopy of your child's health insurance card as a separate sheet with this application.** ***(No staples or glue.)***

PLEASE TURN OVER ➥

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Child's last name: _____ **Child's first name:** _____ MI:____

16) BACKGROUND QUESTIONS

↩ CONTINUED FROM OTHER SIDE

These questions will assist our host families and staff in caring for your child and creating a positive experience.
Please provide us as much information as possible. *Check all boxes that apply.*

Does your child have any other dietary restrictions (e.g. vegetarian, no pork)?

☐ No ☐ Yes → _____

Do you have any non-medical special care recommendations for your child (e.g. religious concerns or others)?

_____

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: _____

Who does your child usually play with?

☐ A large group of friends ☐ A small group of friends ☐ Older children ☐ Younger children

☐ Same age children ☐ Mixed age children ☐ My child plays alone

Does your child have a fear of being in the water? ☐ No ☐ Yes ☐ My child has never experienced water activities.

Has your child been away from home before? ☐ No ☐ Yes → Where? _____

Does your child wet his/her bed? ☐ No ☐ Yes → How often? _____

What are your child's favorite activities? _____

_____

What are your child's favorite foods? _____

Does your child have a favorite nickname? ☐ No ☐ Yes → _____

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: _____

_____

_____

_____

INSTRUCTIONS ON REVERSE For office use only → Please do not cover barcode → N6

Attachment 10 Cont'd
2011 SFSP

Part 1. Children enrolled in Camp or Closed Enrolled Sites.

Names (First, Middle Initial, Last)	SNAP, TANF or FDPIR case # (if any). **Skip to Part 4 if you listed a case #.**

Part 2. Foster Child

Foster children are eligible for free and reduced-price meals regardless of household income. If a foster child lives with you, please contact **[name of Sponsor]** at **[phone number]**. Complete Part 3 if you are applying for other children in your household and you did not enter a SNAP, TANF or FDPIR case number in Part 1.

Part 3. Total Household Gross Income—You must tell us how much and how often

A. Name (List **everyone** in household, including children)	**B. Gross income and how often it was received** *Example: $100/monthly $100/twice a month $100/every other week $100/weekly*				**C. Check if NO income**
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement,	4. All Other Income	
	$______/________	$______/________	$______/________	$______/________	❑
	$______/________	$______/________	$______/________	$______/________	❑
	$______/________	$______/________	$______/________	$______/________	❑
	$______/________	$______/________	$______/________	$______/________	❑
	$______/________	$______/________	$______/________	$______/________	❑
	$______/________	$______/________	$______/________	$______/________	❑
	$______/________	$______/________	$______/________	$______/________	❑
	$______/________	$______/________	$______/________	$______/________	❑
	$______/________	$______/________	$______/________	$______/________	❑
	$______/________	$______/________	$______/________	$______/________	❑
	$______/________	$______/________	$______/________	$______/________	❑
	$______/________	$______/________	$______/________	$______/________	❑

Part 4. Signature and Social Security Number (Adult must sign)

An adult household member must sign this form. If Part 3 is completed, the adult 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 Privacy Act Statement on the back of this page.)

I certify that all information on this form 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 the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: X______________________________ Print name:_____________________________ Date: ______________

Address:____ Phone Number:______________________

Last four digits of Social Security Number: __ __ __ __ ❑ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Asian ❑ White ❑ Black or African American	❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander

Don't fill out this part. This is for official use only.

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

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: ____________

Follow-up Official's Signature: ____ Date: ____________

INCOME ELIGIBILITY FORM FOR THE SUMMER FOOD SERVICE PROGRAM
(For Use by Camps and Closed Enrolled Sites)

Please complete the following form using the instructions below. Sign the form and return it with your application to The Fresh Air Fund. If you need help completing this form, please call **1-800-367-0003.**

Follow these instructions, if your household gets SNAP TANF or FDPIR:

Part 1: List participant's name and a SNAP, TANF or FDPIR case number.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Sign the form. A Social Security Number is NOT required.
Part 5: Answer this question if you choose to.

If your household includes a FOSTER CHILD, use one application for the whole household and follow these instructions:

Part 1: Enter the child's name.
Part 2: Please contact us at **[phone number of Sponsor]**
Part 3: Complete this part if you are applying for other children in the household and you did not enter a SNAP, TANF or FDPIR case number in Part 1.
Part 4: Sign the form. If Part 3 was completed, provide the last four digits of the signing adult's Social Security Number.
Part 5: Answer this question if you choose to.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List each participant's name.
Part 2: Skip this part.
Part 3: Follow these instructions to report total household income from last month.

Column A–Name: List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B–Gross income last month and how often it was received. Next to each person's name, list each type of income received last month, and how often it was received.

In Box 1, list the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).

In box 2, list the amount each person got last month from welfare, child support, alimony.

In box 3, list Social Security, pensions, and retirement.

In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.

Column C–Check if no income: If the person does not have any income, check the box.

Part 4: An adult household member must sign the form and include the last four digits of his or her Social Security Number, or mark the box if he or she doesn't have one.
Part 5: Answer this question if you choose to.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: 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, age, or disability. To file a complaint of discrimination, write to *USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington DC 20250-9410* or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

THIS PAGE IS ONLY FOR CHILDREN APPLYING TO CAMP

Please do not cover barcode →

Child's last name: _____ **Child's first name:** _____ MI:_____

Child's date of birth: _____/_____/_____ Gender: ☐ M ☐ F
Month Day Year

OPTIONAL VISION VAN CONSENT

The Luxottica Foundation's Give the Gift of Sight Vision Van has provided free eye exams and new glasses to thousands of needy children across North America and is now bringing the Gift of Sight to children at our camps. Both the examination and glasses will be donated through the Luxottica Foundation as part of their Give the Gift of Sight program.

If your child needs glasses based on the results of the eye examination provided by a licensed optometrist, a trained Luxottica professional will assist your child in selecting a pair of glasses that are suitable for his/her prescription, face shape, features and coloring.

**Due to the charitable nature of this program, Luxottica, S.p.A. does not provide any breakage protection warranty on the glasses. Luxottica Foundation, Luxottica, S.p.A. and The Fresh Air Fund will not be able to replace glasses that are lost, stolen or broken.*

This section is *not* required for your child to attend our programs, but you must complete these questions and sign below if you would like your child to visit the Vision Van while at camp.

Unfortunately not all children will have the opportunity to visit the Vision Van – dates are not yet confirmed.

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, grandparents, sibling) have any of the following?

Diabetes ☐ No ☐ Yes - Who? _____

Glaucoma ☐ No ☐ Yes - Who? _____

High Blood Pressure ☐ No ☐ Yes - Who? _____

Does your child have any known ALLERGIES? ☐ No ☐ Yes - please list: _____

Is your child currently taking any MEDICATION? ☐ No ☐ Yes - please list: _____

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

_____

As the parent or legal guardian of this child I herby give permission for my son/daughter to receive a free eye exam and glasses, if needed, on the Luxottica Foundation Vision Van at Sharpe Reservation during his/her stay at camp this summer.

By signing below, I acknowledge that Luxottica Retail's **Notice of Privacy Practices** is available from The Fund upon request.

Release of Liability

I release from any liability associated with this event the officers, directors, employees, agents, affiliates, and/or assigns of the following groups: the independent optometrist(s) who perform the eye exam; the cosponsoring agency; Give the Gift of Sight Foundation, and Luxottica, S.p.A..

VISION VAN SIGNATURE **Signature of parent or legal guardian:** _____ **Date:** _____/_____/_____
Month Day Year

the *Fresh Air* fund

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Summer Food Service Program: Information for Parents

This insert is for informational purposes only,
and relates to Page 6 of the Child Application.
Please read it carefully, and then keep this sheet for your own records.

The Fresh Air Fund is participating in the Summer Food Service Program. Federal funds will be made available to The Fresh Air Fund to help cover the costs of meals provided to all eligible children. (For The Fund to be eligible to receive reimbursement for meals at a camp, children must meet the income guidelines for reduced price meals in the National School Lunch Program). Children who are part of households that receive food stamps, or benefits under the Food Distribution Program on Indian Reservations (FDPIR), or Temporary Assistance to Needy Families (TANF) are automatically eligible for the program. The following 2011-2012 income eligibility standards will be used for determining eligibility for reimbursement:

Household Size	**Income Eligibility Guidelines**		
	Yearly	*Monthly*	*Weekly*
1	$20,147	$1,679	$ 388
2	$27,214	$2,268	$ 524
3	$34,281	$2,857	$ 660
4	$41,348	$3,446	$ 796
5	$48,415	$4,035	$ 932
6	$55,482	$4,624	$1,067
7	$62,549	$5,213	$1,203
8	$69,616	$5,802	$1,339
For each additional family member, add:	*$ 7,067*	*$ 589*	*$ 136*

Acceptance and participation requirements for the program and all activities are the same for all regardless of race, color, national origin, sex, age or disability, and there will be no discrimination in the course of the meal service. Meals will be provided at site(s) and times as follows:

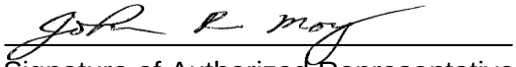
- Camps Anita Bliss Coler (ABC), Hayden Marks Memorial, Hidden Valley, and Tommy will serve Breakfast at 8:00am, Lunch at 12:00pm, and Dinner at 6:00pm on the following dates:
  - Thursday, June 28, 2012 – Monday, July 9, 2012
  - Thursday, July 12, 2012 – Monday, July 23, 2012
  - Thursday, July 26, 2012 – Monday, August 6, 2012
  - Thursday, August 9, 2012 – Monday, August 20, 2012

- Camp Mariah will serve Breakfast at 8:00am, Lunch at 1:00pm; and Dinner at 6:00pm on the following dates:
  - Thursday, June 28, 2012 – Saturday, July 21, 2012
  - Saturday, July 28, 2012 – Monday, August 20, 2012

Please fill out the enclosed "Child Application Page 6: Summer Food Service Program – Camp Eligibility Form" and include it in your application.

Persons interested in receiving more information should contact:
The Fresh Air Fund, 633 Third Avenue, 14th floor, New York, NY 10017 – Tel. 212-897-8900

Any person who believes he or she has been discriminated against in any USDA-related activity should write or call immediately to: USDA, Director, Office of Civil Rights, Room 326-W. Whitten Building, 1400 Independence Avenue, S. W., Washington, D. C. 20250-9410. (202) 720-5964 (voice or TDD).



Signature of Authorized Representative

11/01/2011
Date

the *Fresh Air* fund

serving children since 1877

Income Guidelines for Families Participating in Fresh Air Fund Programs ~ 2012 ~

The Fresh Air Fund's income guidelines are based on the United States Department of Agriculture's guidelines for reduced price meals. We will accept applications from families earning up to $20,000 per year over the USDA guidelines. These guidelines are released annually, and are printed on the other side of this page. The size of a family's household should be calculated including children.

We work hard to serve as many New York City children as possible every year, but since spaces in host families and at camp are limited we can only accept applications for those who meet these guidelines.

Families that earn more than $20,000 per year above the USDA income guidelines are not eligible for any Fresh Air Fund programs. Alternative summer programs can be found by contacting organizations such as the American Camp Association, available at *www.acacamps.com* or *1-800-777-CAMP*.

the *Fresh Air* fund

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Meningococcal Meningitis: Information for Parents

This insert is for informational purposes only,
and is referred to in Page 1 of the Child Application.
Please read it carefully, and then keep this sheet for your own records.

As of August 2003 the New York State Department of Health requires by law that overnight children's camps distribute this information concerning meningococcal disease (meningitis) and its vaccination to the parents and guardians of all campers who attend camp for 7 or more nights.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult, and without early treatment the consequences can be serious. **An official Fact Sheet is provided on the other side of this page to learn more about this disease and its immunization.**

The Fresh Air Fund is required to maintain a record for each camper confirming your receipt of this information. We must also keep a record of each camper's immunization against the disease within the past 10 years **or** of your acknowledgement of the risks of not receiving the vaccination. By filling out the complete Child Application enclosed in this packet, you will be providing us with this information; you do not need to take any further steps.

Vaccination against meningococcal meningitis is not required; we simply need to make sure that you are aware of the disease so that you can make an informed decision about whether or not to have your child vaccinated.

If you require more information about the disease itself, the risks, and its vaccination, please contact your child's doctor.

If you have any further questions, please feel free to call The Fresh Air Fund's Camping Department at 1-800-367-0003.

Turn over this page and read the Fact Sheet to learn more about this disease and its immunization.

Please read the other side of this sheet first.

New York State Department of Health, Bureau of Communicable Disease Control

Meningococcal Disease: Fact Sheet

Information for College Students and Parents of Children at Residential Schools and Overnight Camps

What is meningococcal disease?
Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord).

Who gets meningococcal disease?
Anyone can get meningococcal disease, but it is more common in infants and children. For some college students, such as freshmen living in dormitories, there is an increased risk of meningococcal disease. Between 100 and 125 cases of meningococcal disease occur on college campuses every year in the United States; between 5 and 15 college students die each year as result of infection. Currently, no data are available regarding whether children at overnight camps or residential schools are at the same increased risk for disease. However, these children can be in settings similar to college freshmen living in dormitories. Other persons at increased risk include household contacts of a person known to have had this disease, immunocompromised people, and people traveling to parts of the world where meningitis is prevalent.

How is the germ meningococcus spread?
The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person. Many people carry this particular germ in their nose and throat without any signs of illness, while others may develop serious symptoms.

What are the symptoms?
High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. Among people who develop meningococcal disease, 10-15% die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

How soon do the symptoms appear?
The symptoms may appear 2 to 10 days after exposure, but usually within 5 days.

What is the treatment for meningococcal disease?
Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

Is there a vaccine to prevent meningococcal meningitis?
Yes, a safe and effective vaccine is available. The vaccine is 85% to 100% effective in preventing four kinds of bacteria (serogroups A, C, Y, W-135) that cause about 70% of the disease in the United States.

Is the vaccine safe? Are there adverse side effects to the vaccine?
The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days.

What is the duration of protection from the vaccine?
After vaccination, immunity develops within 7 to 10 days and remains effective for approximately 3 to 5 years. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals.

How do I get more information about meningococcal disease and vaccination?
Contact your family physician or your student health service. Additional information is also available on the websites of the New York State Department of Health, *www.health.state.ny.us*; the Centers for Disease Control and Prevention *www.cdc.gov/ncid/dbmd/diseaseinfo*; and the American College Health Association, *www.acha.org*.

Information about the cost of the vaccine:
The cost of the vaccine may be covered by your child's health insurance. In addition, the New York State Department of Health has informed The Fresh Air Fund that the vaccine is covered once for each recipient in fee-for-service Medicaid and/or each enrollee in a Medicaid managed care plan.