2025 Summer Program Parent Registration Guide

FAQs

When is the Limitless Summer Program?
July 1st - August 15th 2025. If you have registered for half days the day will begin at 9:00 am and end at noon. Full days are from 9 am to 3:30 pm. We also offer an extended day of after care that runs from 3:30 pm to 5:00 pm.

Where is it?
St. Christophers Church. 1050 Littleton Road in Parsippany.

How much does it cost?
A table of costs can be found on our website https://www.limitlessasd.com/2025summerprogram

Is my district paying for the Summer Program or the Extended Hours Program?
Please consult your district case manager to confirm whether your child's district will be covering the cost of Limitless programs.

When is registration due?
May 16th, 2025.

When should I expect confirmation of registration?
Registration confirmations along with a list of any missing documents will be sent by email no later than May 23rd Please read the Parent Registration Process contained in this packet.

When is payment due?
Payment is due July 1st. No refunds for cancellations will be granted after this date. Please email us at cfarr@LimitlessASD.com or call us at 973.448.7529 to request an extension if you are unable to make a payment by July 1st.

When will I know who my child's teacher is?
Two weeks prior to the start of the summer program, you will receive a packet including a request for specific student information; a program schedule; a program calendar; your child's placement; and a 'Things You Need for the Program' memo.

Are there any field trips or events I should know about?
Please refer to the calendar you will be receiving as part of the packet mentioned above. Note that the calendar is subject to change. Any information regarding specific trips or events during the summer program will be communicated to you by your child's teacher or by memo.

Who do I contact if I have questions?
Please email cfarr@LimitlessASD.com with any questions.

Do you provide transportation?
Limitless does not currently provide transportation for the summer program. Transportation to and from the summer program is handled by your child's district. For further information, please contact your district case manager.

Registration Links, Due Dates, and Forms

Enclosed you will find all the information and forms you will need to register for 2025.

We are happy to answer any questions you may have regarding our summer program. For additional Information check our website at www.LimitlessASD.com, or email us at info@LimitlessASD.com to request information or to set up a phone call.

The Limitless Summer Program is provided by DCCF, LLC, which is a private, Board of Health approved summer facility.

Step 1	Step 2	Step 3
What: Register your child on our website. **here:** https://www.limitlessasd.com/summer-program-registration **When:** Registration deadline is May 16th	**What:** Complete and submit the Universal Child Health Record by email to info@limitlessasd.com or mail to 30 Righter Ave, Denville, NJ 07834 **Where:** Page 6 of this document. **When:** By June 20th	**What:** Complete and submit the Camper Health History Form 1 and 2 by email to info@limitlessasd.com or mail to 30 Righter Ave, Denville, NJ 07834 **Where:** Page 9 of this document. **When:** By June 20th

Complete the following steps if applicable:

Step 4	Step 5	Step 6
What: Complete and submit the Medication Administration Form by email to info@limitlessasd.com or mail to 30 Righter Ave, Denville, NJ 07834 **Where:** Page 16 of this document. **When:** By June 20th	**What:** Register your child for after care **Where:** https://www.limitlessasd.com/summer-program-registration **When:** June 20th	**What:** Pay your invoice if the program is not being covered by your child's district or if you enrolled your child in After Care. **Where:** Invoices will be sent via email and can be paid online by debit or credit card or you may send a check to Limitless at 30 Righter Ave in Denville, NJ 07834 **When:** July 1st

2025 Summer Program Registration Guide for Parents

Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Register	Universal Child Health Record	Camper Health History Form 1 and 2	*Medication Form *If Applicable	*Extended Hours Registration *If Applicable	*Pay Invoice *If Applicable

Visit our website by May 16th to register your child for the Limitless 2025 Developmental Summer Program.

July 1st - August 16th, 2025

9:00 am - 12:00 pm

9:00 am - 3:30 pm

3:30 pm - 5:00 pm

https://www.limitlessasd.com/summer-program-registration

Register from 1 to 7 Weeks!		Full Day	1:1 Aide	Half Day	1:1 Aide	After-care
		9:00-3:30		9:00-12:00		3:30-5:00
Week 1	July 1st - July 3rd	$1,228	$546	$567	$261	120
Week 2	July 7th - July 11th	$2,048	$910	$945	$435	200
Week 3	July 14th - July 18th	$2,048	$910	$945	$435	200
Week 4	July 21st - July 25th	$2,048	$910	$945	$435	200
Week 5	July 28th - Aug 1st	$2,048	$910	$945	$435	200
Week 6	Aug 4th - Aug 8th	$2,048	$910	$945	$435	200
Week 7	Aug 11th - Aug 15th	$2,048	$910	$945	$435	200

12:00-1:00 and 3:00 - 4:30 OT, PT, Speech, Tutoring, DIR-5C's Therapy, Parent Coaching $80/Hour

Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Register	Universal Child Health Record	Camper Health History Form 1 and 2	***Medication Form** *If Applicable	*Extended Hours Registration *If Applicable	*Pay Invoice *If Applicable

Complete and submit the Universal Child Health Record. The form and directions to complete the form are on the next two pages.

Please submit the completed health record by June 20th.

This form must be completed by a parent or guardian AND your child's physician.

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.
2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860.
   - The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.
3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.
   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

   PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.
4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.
5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Register	Universal Child Health Record	Camper Health History Form 1 and 2	***Medication Form** *If Applicable	*Extended Hours Registration *If Applicable	*Pay Invoice *If Applicable

Complete and submit the Camper Health History Form 1 and 2.

The forms along with directions are on the following five pages.

Directions:

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1) Complete pages 1, 2, and 3 of this form (FORM 1) and make a copy.
2) Send the original, signed FORM 1 to camp by June 3rd.
3) Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.
4) After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by June 20th.

CAMPER HEALTH HISTORY FORM1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

american CAMP association®

Mail this form to the address below by _____ (date)

Dates will attend camp: from _____ (Month/Day/Year) to _____ (Month/Day/Year)

Camper Name: _____ (First) _____ (Middle) _____ (Last)

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp: _____

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1) *Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.*
2) *Send the original, signed FORM 1 to camp by the requested date.*
3) *Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.*
4) *After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.*

Camper Home Address: _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Email: _____

Home Address: _____ (If different from above) (Street Address) (City) (State) (Zip Code)

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Allergies: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet. ☐ This camper is lactose intolerant. ☐ This camper is gluten intolerant. ☐ Other, ***please explain in space.***

Restrictions:

☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. ***(Please describe below.)***

Medical Insurance Information:

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company_____ Policy Number_____

Subscriber_____ InsuranceCompany Phone Number (_____)_____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Camper: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Camper Name _____ (First) _____ (Middle) _____ (Last) (For Camp Use) Cabin or Group _____ (For Camp Use) Session Code(s): _____

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must include date to meet ACA Standard. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster★ (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐ Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative ☐ Positive

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

Medication:
☐ This camper will not take any daily medications while attending camp.
☐ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

1. Ever been hospitalized?	☐ Yes ☐ No	11. Had fainting or dizziness?	☐ Yes ☐ No
2. Ever had surgery?	☐ Yes ☐ No	12. Passed out/had chest pain during exercise?	☐ Yes ☐ No
3. Have recurrent/chronic illnesses?	☐ Yes ☐ No	13. Had mononucleosis ("mono") during the past 12 months?	☐ Yes ☐ No
4. Had a recent infectious disease?	☐ Yes ☐ No	14. If female, have problems with periods/menstruation?	☐ Yes ☐ No
5. Had a recent injury?	☐ Yes ☐ No	15. Have problems with falling asleep/sleepwalking?	☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath?	☐ Yes ☐ No	16. Ever had back/joint problems?	☐ Yes ☐ No
7. Have diabetes?	☐ Yes ☐ No	17. Have a history of bedwetting?	☐ Yes ☐ No
8. Had seizures?	☐ Yes ☐ No	18. Have problems with diarrhea/constipation?	☐ Yes ☐ No
9. Had headaches?	☐ Yes ☐ No	19. Have any skin problems?	☐ Yes ☐ No
10. Wear glasses, contacts, or protective eyewear?	☐ Yes ☐ No	20. Traveled outside the country in the past 9 months?	☐ Yes ☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life? ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s): _____ Phone: (_____) _____

Name of orthodontist(s): _____ Phone: (_____) _____

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. ***Attach additional information if needed.***

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Individual Health Record (For Camp Use Only)

Initial Screening Date/Time: _____ Initials: _____

☐ Screening has been conducted according to camp protocol and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival?..... ☐ No ☐ Yes as noted below

B. History of exposure to communicable disease?..... ☐ No ☐ Yes as noted below

C. Additions or corrections to information on this health history?..... ☐ No ☐ Yes as noted below

D. Medication given to health-care staff?..... ☐ No ☐ Yes as noted below

E. Any signs/symptoms of head lice?..... ☐ No ☐ Yes as noted below

Provider notes: (date/time/initial all entries) _____

Exit Note: Check one of the following:

☐ Left camp this day with no reported illness or injury symptoms.

☐ Left camp this day with the following problem/concern:

_____

This person was told about the problem and instructed about follow-up as noted above: _____

Date/Time: _____ Initials: _____

Rev.1/2014 LEE/EAW

Recommendations for Licensed Medical Personnel

FORM 2

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

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Mail this form to the address below by _____ (date)

To Parent(s)/Guardian(s): Complete this section and give this form (FORM 2) and a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1) to your child's health-care provider for review.

Dates will attend camp: from _____ (Month/Day/Year) to _____ (Month/Day/Year)

Camper Name: _____ (First) _____ (Middle) _____ (Last)

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp _____

Camper home address: _____

_____ (City) _____ (State) _____ (Zip Code)

Custodial parent(s)/guardian(s) phone: (_____) _____ (_____) _____

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. ***Medical personnel: Cross out those items the camper should not be given.***

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)
- Chlorpheneramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimite)
- Calamine lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today: ☐ Yes ☐No **(If "No," date of last physical:** _____ (Month/Day/Year)**)**

ACA accreditation standards specify physical exam within the last 12 months.

Weight: _____ lbs Height: _____ft_____in Blood Pressure_____/_____

Allergies: ☐ No Known Allergies

☐ To foods ***(list)***:

☐ To medications: ***(list)***:

☐ To the environment ***(insect stings, hay fever, etc.– list)***:

☐ Other allergies: ***(list)***:

Describe previous reactions:

Diet, Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions:(describe below)

The camper is undergoing treatment at this time for the following conditions: ***(describe below)*** ☐ None.

Medication: ☐ No daily medications. ☐ Will take the following prescribed medication(s) while at camp: ***(name, dose, frequency—describe below)***

Other treatments/therapies to be continued at camp: ***(describe below)*** ☐ None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes

If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print): _____ Signature: _____ Title: _____

Office Address _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Telephone: (_____) _____ Date: _____

 Inc. Rev. 1/14 LEE/EAW

Camper Name _____ (First) _____ (Middle) _____ (Last)

(For Camp Use) Cabin or Group _____

(For Camp Use) Session Code(s): _____

Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Register	Universal Child Health Record	Camper Health History Form 1 and 2	***Medication Form** *If Applicable	*Extended Hours Registration *If Applicable	*Pay Invoice *If Applicable

If your child needs medication administered during the Limitless Summer Program between 9:00 am and 3:30 pm the Medication Administration Form must be filled out.

Please note that there WILL NOT be a nurse on staff during After Care (3:30 pm - 5:00 pm) to administer medication

The Medication Administration Form is on the following page.

Ph: 973.448.7529
Fax: 973.691.5657

Email:
info@limitlessASD.com

30 Righter Ave
Denville, N.J. 07834

Leveraging Diversity for Success in the 21st Century

Medication Administration Form

Physician's Section:

Camper's Name: _____ Date: _____

Was treated for (diagnosis) _____

I request the camp nurse to administer medication prescribed by me for the following period:

From: _____ To: _____

Date Date

Rx: _____

Dosage: _____

Side Effects: _____

Physician's Signature: _____ Date: _____

Physician's Name: _____

Physician's Phone: _____

Parent/Guardian Section:

I understand and agree that the medication to be administered in camp must be delivered in the original container accompanied by the completed and signed form.

I give my permission to the camp nurse to administer the above-prescribed medication.

Parent/Guardian Signature: _____ Date: _____

Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Register	Universal Child Health Record	Camper Health History Form 1 and 2	***Medication Form** *If Applicable	*Extended Hours Registration *If Applicable	*Pay Invoice *If Applicable

Register online for After Care by June 20th.

Extended Hours Program
July 1st - August 15th
3:30 pm - 5:00 pm

https://www.limitlessasd.com/summer-program-registration

Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Register	Universal Child Health Record	Camper Health History Form 1 and 2	***Medication Form** *If Applicable	*Extended Hours Registration *If Applicable	*Pay Invoice *If Applicable

Payment is due by July 1st.

If the Limitless Summer Program or After Care is not covered by your child's district you must submit payment by July 1st.

Invoices may be paid through a link in an invoice sent to your email or by check or cash.

Please make checks payable to Limitless.