REGISTER ONLINE AT www.4hcampct.og

CAMP APPLICATION - 2019 WINDHAM-TOLLAND 4-H CAMP - FORM A

Camper's Name (Last Name)________________________________(First Name)________________________________

Mailing Address________________________________, Town ________________, State________________, Zip Code ________

Boy _____ Girl _____ Date of Birth (Month, Day, Year) ____________________ Age ___________ School Grade in Sept., 2019________________

Parent/Guardian's Name________________________________ Email Address ________________________________

Home Phone (_____) ____________ Work Phone (______) ____________Cell Phone (______) ________________

Alternate Emergency, please contact:____

Home Phone (______) ____________ Work Phone (______) ____________Cell Phone (______) ________________

Please circle your choice below:

RESIDENT (Overnight) CAMP	Sun 2:30 PM – 4 PM thru Fri 7 PM	(Boys & Girls, Ages 9-15**)**
DAY CAMP	Mon thru Fri - 8-8:30 AM – 5-5:30 PM	(Boys & Girls, Ages 6-15)
CLOVER CAMP A, C, E, or G	Mon 8:00 AM thru Tues 5 PM	(All Clover Boys & Girls, Ages 7-8)
CLOVER CAMP B, D, F, or H	Wed. 8:00 AM thru Fri 7 PM	(All Clover Boys & Girls, Ages 7-8)
EXPERIENCED CLOVER CAMP I, J, & K	Same Schedule As Resident Camp	(All Clover Boys & Girls, Ages 7-8)

RESIDENT CAMP ***June 23- June 28 (WK 1)*** ***Disney Week***	**RES** General $475	**DAY** General $275	**CLOVER A** 6/24 - 6/25 Mon - Tues $190	**CLOVER B** 6/26 – 6/28 Wed - Fri $260	**DAIRY COW CAMP $25**	**WOOD FIBER CRAFTS $25**	**(9+ Yrs Old)** Riding + $175
RESIDENT CAMP ***June 30-July 5 (WK 2)*** ***4-H Spirit Week***	**RES** General $475	**DAY** General $275	**CLOVER C** 7/1 – 7/2 Mon - Tues $190	**CLOVER D** 7/3 – 7/5 Wed - Fri $260	**BEEF COW CAMP $25**	**WOOD FIBER CRAFTS** $25	Riding + $175
RESIDENT CAMP ***July 7 -July 12 (WK 3)*** ***Carnival Week***	**RES** General $475	**DAY** General $275	**CLOVER E** 7/8 – 7/9 Mon - Tues $190	**CLOVER F** 7/10 – 7/12 Wed - Fri $260	**WOOD FIBER CRAFTS $25**		Riding + $175
July 12-July 14 (RESIDENT CAMP ONLY)	**Stayover Weekend - Available to campers enrolled for both weeks 3 and 4 (Includes a FUN TRIP to The Boston Science Museum on Saturday & Laundry Service) $225**						
RESIDENT CAMP ***July 14-July 19 (WK 4)*** ***Wild Wild West Week***	**RES** General $475	**DAY** General $275	**CLOVER G** 7/15 – 7/16 Mon - Tues $190	**CLOVER H** 7/17– 7/19 Wed- Fri $260	**WOOD FIBER CRAFTS $25**		Riding + $175
RESIDENT CAMP ***July 21-July 26 (WK 5)*** ***International Week***	**RES** General $475	**DAY** General $275	**Experienced Clovers I** $475		**WOOD FIBER CRAFTS $25**		Riding + $175
RESIDENT CAMP ***July 28-August 2 (WK 6)*** ***Safari Week***	**RES** General $475	**DAY** General $275	***Experienced Clovers J*** *$475*		**WOOD FIBER CRAFTS $25**		Riding + $175
RESIDENT CAMP ***August 4-August 9 (WK 7)*** ***Super Splash Week***	**RES** General $475	**DAY** General $275	**Experienced Clovers K $475**		**WOOD FIBER CRAFTS $25**		Riding + $175
DAY CAMP ONLY August 12- August 16(WK8) Capture the Flag Week	**Check-in registration is on Monday Morning Week 8 Only DAY CAMP ONLY $275**				***WOOD FIBER CRAFTS $25***		

A CONFIRMATION LETTER TO EACH CAMPER WILL BE MAILED AFTER YOUR REGISTRATION IS PROCESSED. I understand that there is a non-refundable $200.00 deposit for Resident Camp and Experience Clovers, a $100.00 non-refundable deposit for Day Camp and Teen Leaders and a $50.00 non-refundable deposit for Clover Camp and Horseback Riding. I also understand there are NO REFUNDS FOR EARLY DISMISSAL DUE TO HOMESICKNESS, MISCONDUCT OR MEDICAL REASONS

PAYMENT METHOD: ***A 50% deposit for each camper per week per session is required.***

☐ Check/ money order enclosed payable to: **Windham-Tolland 4-H Camp**. Amount: $________________

☐ VISA/Discover/MasterCard # __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Exp. Date __ __ __ __ Amount: $________________

☐ I authorize the balance to be charged to my credit card on May 24th , 2019. (Please check if desired.)

I wish to bunk with (MAXIMUM OF ONE CAMPER ONLY) ______________________, age____ (MUST BE SAME AGE). Both friends must request each other on their applications. Applications with more than one person requested for bunking will not be accepted.

________________________________ ________________________________Date__________

Signature of Parent/Guardian ***Cardholder Signature/Parent/Guardian***

RETURN TO: WINDHAM-TOLLAND 4-H CAMP, 326 TAFT POND ROAD, POMFRET CENTER, CT 06259
Fax (860) 974-3327

CAMPER INFORMATION MEDICAL FORM – FORM C

Camper's Full Name____

DOB________________ Age_________ Home Ph____

Address____ City_________________________ State______

Parent/Guardian #1____Relationship_____________________

Cell Ph____ Work/Other Ph___________________________________

Email____

Parent/Gaurdian#2____ Relationship____________________

Cell Phone____ Work/Other Ph __________________________________

Email____

Name of additional emergency contact(s):

_____________________________________ Ph________________________________ Relationship__________________

_____________________________________ Ph_________________________________ Relationship__________________

Health Insurance Company____

Insurance Policy #____

Insurance carried by_______________________________________ Employer___________________________

HEALTH HISTORY

Date of Last Physical Exam: ____________________ ****Must be within last 2 years and provided to camp. ****

Last Tetanus Immunization:____________________

Primary Care Physcian :______________________________ Phone:_____________________________________

Current weight_______ Current height______

PERMISSION TO TREAT

Connecticut law states that except in the case of an emergency which threatens life or limb, parent or guardian must sign consent to treat for a patient under the age of 18. Please complete this section to allow your camper to receive treatment for accident, injury or illness at a medical facility.

- **Camper will transported to nearest hospital, Day Kimball Hospital in Putnam, CT**
- **On stay-over weekend, camper will be brought to hospital nearest to field trip location.**
- **Camp staff will always notify parent/guardian of need for medical care.**
- **Camper Health History and Registration Forms will be shared with Medical Facility.**

I request and authorize, Day Kimball Hospital, or nearest medical center, and its personnel to deliver medical care to my child listed here: ____. I also authorize the Windham Tolland 4-Camp to share Camper and Health History with the Medical Provider. This authorization will expire one year from date of signature unless otherwise stated.

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed camp activities except as noted. EMERGENCY AUTHORIZATION: I hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine tests and treatment for me(staff) or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure treatment for and to order injection and/ or anesthesia and/or surgery for me(staff)/or my child as named above. This form may be photo-copied for use out of camp. I also give permission for the camp to provide routine medical care for my child.

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

____ ______________________

Signature (Parent/Guardian/Adult Staff Member) Date

____ ____________________________________

Printed Name (Parent/Guardian/Adult Staff Member) Relationship to camper

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Name: ___________________________________ Age: ________________ FORM D – PLAN OF CARE

The following questions are required for ALL campers. It is used to identify campers who require a plan of care to maintain health and maximize participation in the camp program.

PLEASE CHECK ALL THAT APPLY AND COMPLETE APPLICABLE SECTIONS:

___My child has a food allergy(s) to:____

___My child has non-food allergy(s) to:____

The plan of care is ___Avoidance

___Medication as ordered. Please attach doctor's order.

___Other, please specify____

___My child requires medication for treatment of____

Please attach doctors' orders, **CAMP FORM E** or school form is acceptable.

___My child has special dietary, dental or oral needs: ____

The plan of care is____

____

___My child is ____hearing or ____vision impaired.

The plan of care is____

____

___My child as a chronic illness or diagnosis of____

The plan of care is____

____

___My child has cognitive, emotional and/or physical developmental needs related to the diagnosis of :

____

The best way to support my child with this is to :____

____

____

___My child has had a serious illness, hospitalization or accident in the last 12 months. Please explain.______________

____

___My child has required psychiatric counseling/hospitalization. _____________________________________

___ Any Specific activities to be limited by physician's advice. (Send with Physician's orders)

___**Check here to be contacted by Camp Nurse to further discuss and plan for the needs of your child. Please indicate best number or email for contact**____

___My child DOES NOT require any plan of care for special health needs.

____ ______________________________

Parent/Guardian Signature Date

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THIS FORM REQUIRES PHYSICIAN'S SIGNATURE
AND PARENT/GUARDIAN'S SIGNATURE
FOR PRESCRIBED MEDICATIONS

Camper's Name: Last____________________ First ______________ Middle ___________________

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY YOUTH CAMP PERSONNEL

If a Youth Camp chooses to administer medications, the Connecticut State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse, first aide, the director, alternate director or youth camp counselor to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, physician's or dentist's name and date of the original prescription.

MEDICATIONS CURRENTLY BEING TAKEN (Meds brought to camp must be in their original labeled pharmacy container.)

Med #1_________________________________ Dosage_______Specific times taken each day______________________
Reason for taking

____

Med #2_________________________________ Dosage_______Specific times taken each day______________________
Reason for taking

____

Med #3_________________________________ Dosage_______Specific times taken each day______________________
Reason for taking

____

Med #4_________________________________ Dosage_______Specific times taken each day______________________
Reason for taking

____

ATTACH ADDITIONAL PAGES FOR MORE MEDICATIONS.

Identify any medications taken during the school year that participant does/may not take during the summer:

__________________________ __________________________ ____________________

AUTHORIZATION FOR LICENSED MEDICAL PERSONNEL (PHYSICIAN OR DENTIST)

The person named herein may be administered the medications indicated above. In the event the camp nurse is unavailable, camper/staff member (check one) ______________may ___________ may not self-administer this medication under the supervision of camp first aide personnel.

Signature_______________________________________ Title___________________________________
Physician or Dentist Signature
Printed____ License #______________________________
Address____ City/State/Zip___________________________
Telephone #_____________________________________ Date___________________________________

AUTHORIZATION FOR PARENT/GUARDIAN

I hereby authorize the camp nurse to administer the medications indicated above as ordered by my physician and the camp physician. In the event the camp nurse is unavailable, camper/staff member (check one) ___________ may ___ may not self-administer this medication under the supervision of camp first aid personnel.

Signature_______________________________________ Relationship to Child______________________
Printed Name____________________________________ Date___________________________________
Parent/Guardian Signature

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- ❑ Camper
- ❑ Staff

FORM F – RETURN WIITH FORMS A, B, C, D, E

MEDICAL EVALUATION

MUST BE GOOD WITHIN 2 YEAR OF CAMPERS LAST DAY AT CAMP

MEDICAL PRACTITIONER MUST COMPLETE AND SIGN

Name____________________ Date of Birth____________________

Guardian____________________ Address____________________

Home Phone ( ) __________ Work Phone ( ) __________ Cell Phone ( ) __________

Emergency Contact #1____________________ Home Phone ( ) __________ Cell Phone ( ) __________

Emergency Contact #2____________________ Home Phone ( ) __________ Cell Phone ( ) __________

Date of Arrival at Camp:____________________ Departure Date:____________________

Date of Exam____________________

________ **May participate in all camp activities.**

________ **May participate except for:**____________________

Medical information pertinent to routine care and emergencies:____________________

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunizations Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus			TB Test		Result:

Comments:____________________

Health History: (Check any that apply)

________ Epilepsy or seizures ________ Frequent ear infections ________ Menstrual problems ________ Asthma

________ Frequent sore throats ________ Headaches ________ Bed wetting ________ Heart Disease

________ Back pain or strain ________ Alcohol/drug addiction ________ Diabetes ________ Eye Glasses

________ Heart Disease OTHER:____________________

Pertinent past medical treatment:____________________

ALLERGIES **Describe reaction and management of reaction**

Medication Allergies

____________________ ____________________

____________________ ____________________

Food Allergies

____________________ ____________________

____________________ ____________________

Other Allergies (including: insect stings, hay fever, asthma, animal dander, etc.)

____

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

____________________**, M.D. Telephone:(** **)**__________**Date:**__________

Examining Physician

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FORM G – OVER-THE-COUNTER MEDICATIONS
Return with Forms A, B, C, D, E, F

THIS FORM REQUIRES PARENT/GUARDIAN'S SIGNATURE TO AUTHORIZE THE ADMINISTRATION OF ANY OVER-THE-COUNTER MEDICATIONS

Camper's Name: Last__________________________ First _________________________________

I DO WISH OVER-THE-COUNTER MEDICATIONS TO BE GIVEN TO MY CHILD.

I understand the Health Care Provider will administer the following over-the-counter medication or the generic version, if necessary, according to directions on the bottles unless a physician directs otherwise. The Camp provides over-the-counter medications.

Symptom:	Over-The-Counter Medication:
Athletes Feet	Desenex or similar powder/spray
Skin irritations	Gold Bond Powder
Minor aches/pain/fever	Tylenol/Advil/Ibuprofen/Alleve
Minor cough/sore throat	Robitussin/Cough/Throat Drops/Chloraseptic Throat Spray
Minor Allergic Reactions/Allergies	Benadryl, Claritin, Xyzel and Zyrtec
Poison Ivy/Rashes	Calagel Lotion/Calamine Lotion
Bug Bites	Benzocaine Swabs/Dermoplast Hydrocortisone Cream/Benadryl Cream
Indigestion/Heartburn	Antacid/Pepto Bismol/Tums
Constipation	Milk of Magnesia
Clogged Ears	Auro-Dry
Open Areas/Cuts	Bacitracin/Triple Antibiotic ointment
Lactose Intolerant	Lactaid tablets

If any medication is not listed above, you must obtain a doctor's signature in order for the Camp Nurse to give said medication to your camper.

____ **Date:** ________________________________

Signature of Parent or Legal Guardian

Print Parent or Legal Guardian's Name____

Parent's Home Phone (_____)____________________ Work Phone (_____)____________ Cell Phone (______)_________________

==

I DO NOT WISH ANY MEDICATIONS TO BE GIVEN TO MY CHILD, ______________________________________.
Camper's Full Name

____ **Date:**___________________________

Signature of Parent or Legal Guardian

Print Name of Parent or Legal Guardian ____

Parent's Home Phone (___)______________________ Work Phone (___)______________________ Cell Phone (_____)______________

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