

**REGISTER ONLINE AT [www.4hcampct.org](http://www.4hcampct.org)  
CAMP APPLICATION - 2021 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., 2021 \_\_\_\_\_

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:**

<b>RESIDENT (Overnight) CAMP DAY CAMP</b>	Sun 2:30 PM – 4 PM thru Fri 7 PM	(Boys & Girls, Ages 9-15)
<b>CLOVER CAMP A, C, E, or G</b>	Mon thru Fri - 8-8:30 AM – 5-5:30 PM	(Boys & Girls, Ages 6-15)
<b>CLOVER CAMP B, D, F, or H</b>	Mon 8:00 AM thru Tues 5 PM	(All Clover Boys & Girls, Ages 7-8)
<b>EXPERIENCED CLOVER CAMP I, J, &amp; K</b>	Wed. 8:00 AM thru Fri 7 PM	(All Clover Boys & Girls, Ages 7-8)
	Same Schedule As Resident Camp	(All Clover Boys & Girls, Ages 7-8)
Circle your week choice(s):		<b>Special Activities (add'l Fees Apply)</b>
<b>WEEK 1 – Scooby Doo Wk</b> <i>June 20 - June 25</i>	<b>RES</b> \$525	<b>DAY</b> \$325
	<b>CLOVER A</b> 6/20 - 6/22 Sun - Tues \$275	<b>CLOVER B</b> 6/23 - 6/25 Wed - Fri \$275
		<b>(9+ Yrs Old)</b> Riding + \$210
<b>WEEK 2 – Medieval Wk</b> <i>June 27 - July 2</i>	<b>RES</b> \$525	<b>DAY</b> \$325
	<b>CLOVER C</b> 6/27 - 6/29 Sun - Tues \$275	<b>CLOVER D</b> 6/30 - 7/2 Wed - Fri \$275
		<b>COW CAMP</b> \$25
		Riding + \$210
<b>WEEK 3 – Carnival Wk</b> <i>July 4 - July 9</i>	<b>RES</b> \$525	<b>DAY</b> \$325
	<b>CLOVER E</b> 7/4 - 7/6 Sun - Tues \$275	<b>CLOVER F</b> 7/7 - 7/9 Wed - Fri \$275
		Riding + \$210
<b>WEEK 4 – Game Show Mania Wk</b> <i>July 11 - July 16</i>	<b>RES</b> \$525	<b>DAY</b> \$325
	<b>CLOVER G</b> 7/11 - 7/13 Sun - Tues \$275	<b>CLOVER H</b> 7/14 - 7/16 Wed - Fri \$275
		Riding + \$210
<b>WEEK 5 – International Wk</b> <i>July 18 - July 23</i>	<b>RES</b> \$525	<b>DAY</b> \$325
	<b>Experienced Clovers I</b> \$525	
		Riding + \$210
<b>WEEK 6 - Decades Wk</b> <i>July 25 - July 30</i>	<b>RES</b> \$525	<b>DAY</b> \$325
	<b>Experienced Clovers J</b> \$525	
		Riding + \$210
<b>WEEK 7 – Water Splash Wk</b> <i>August 1 - August 6</i>	<b>RES</b> \$525	<b>DAY</b> \$325
	<b>Experienced Clovers K</b> \$525	
		Riding + \$210
<b>WEEK 8 – Capture the Flag Wk</b> <i>August 8 - August 13</i>	<b>DAY CAMP ONLY</b> \$325	

A CONFIRMATION LETTER TO EACH CAMPER WILL BE MAILED AFTER YOUR REGISTRATION IS PROCESSED. I understand that there is \$200.00 deposit for Resident Camp and Experience Clovers, a \$100.00 deposit for Day Camp and Teen Leaders and a \$50.00 deposit for Clover Camp and Horseback Riding. No refunds after May 21, 2021. I also understand there are NO REFUNDS FOR EARLY DISMISSAL DUE TO HOMESICKNESS, MISCONDUCT OR MEDICAL REASONS (please see website for complete refund policy).

**PAYMENT METHOD: A 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 21 2021. (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.

\_\_\_\_\_  
**Signature of Parent/Guardian** \_\_\_\_\_ **Cardholder Signature (if paying by credit card)** \_\_\_\_\_ Date \_\_\_\_\_

FORM B (Please return with Forms A, B, C, D, E, F & G)

WINDHAM-TOLLAND 4-H CAMP
CODE OF CONDUCT AGREEMENT
FOR CAMPER, TEEN LEADERS AND PARENTS

I, the undersigned camper/teen leader and parent/legal guardian have read the basic rules for participation at the Windham-Tolland 4-H Camp program outlined below and agree to abide by the rules.

Campers will:

- Participate fully in the program.
Be responsible for his/her own behavior and uphold standards for their peers.
Follow all scheduled times, including curfew and wake-up.
Will dress appropriately for a co-ed outdoor recreation experience.

Campers will not:

- Leave the camp premises without staff supervision and director permission.
Disobey directives from camp staff or camp policies, rules and regulations.
Be disrespectful or direct profanity, vulgar language, or obscene gestures towards other campers or camp staff or wear offensively worded or graphic clothing.
Play with matches, fire, or commit arson.
Partake in the theft or the unauthorized removal of camp property, staff property or camper property.
Fight, provoke fighting or commit physical abuse to others or themselves.
Commit extortion, coercion or blackmail that force an individual(s) to act through the use of force or threat of force.
Make derogatory statements that may substantially disrupt the camp program or insight violence.
Engage in sexual harassment: any unwelcome sexual advance or conduct including lewd remarks, touches, or request for sexual favors that have the effect of intimidating individuals or disrupting the camp environment will not be tolerated.
Sell, give, deliver, possess, use or be under the influence of drugs, alcohol or tobacco products. This includes the misuse of prescription and over the counter medications. THIS INCLUDES ALL VAPING.
Haze other campers.
Possess a weapon or dangerous instrument to be used as a weapon.
Violate local, state or federal laws.
Intentionally damage camp facilities including graffiti; you will be billed for damages.
Bring electronic equipment including but not limited to: cell phones, CD players, MP3 players, iPods, video games, radios, or Kindles and Nooks or other electronic devices.

- Failure to comply with these rules may result in but not be limited to a "time-out" from an activity, removal from a program area or expulsion from the camping program. Corporal Punishment is not permitted at the Windham-Tolland 4-H Camp. Violations of local, state or federal laws will be reported to the authorities.
I understand that there is a \$200.00 deposit for Resident Camp and Experience Clovers, a \$100.00 deposit for Day Camp and Teen Leaders and a \$50.00 deposit for Clover Camp and Horseback Riding. There are NO REFUNDS AFTER May 21, 2021. I also understand there are NO REFUNDS FOR EARLY DISMISSAL DUE TO HOMESICKNESS, MISCONDUCT OR MEDICAL REASONS. (please see website for complete refund policy)
PERMISSION FORM - Complete a separate application form for each child. I hereby give permission for the named camper to attend the Windham-Tolland 4-H Camp and to participate in all activities, subject to the authority of the camp director. I further give permission for the named camper to participate in any planned out-of-camp outings or trips under the supervision of the director or assigned staff member. I will not hold the Windham-Tolland 4-H Camp responsible for the loss of money, jewelry, or personal articles brought to camp. I also give my permission for use of any photo of the named camper to be used by the Camp Committee for camp public relations.

Optional Information:

Ethnicity: Hispanic or Latino \_\_\_\_\_ Not Hispanic or Latino \_\_\_\_\_
Race: White \_\_\_\_\_ Black/African American \_\_\_\_\_ Asian \_\_\_\_\_
American Indian/Alaskan Native \_\_\_\_\_ Native Hawaiian/Pacific Islander \_\_\_\_\_

BOTH CAMPER AND PARENT/ LEGAL GUARDIAN MUST SIGN THIS CODE OF CONDUCT.

Signature of Camper AND Signature of Parent/ Legal Guardian Date :

**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 Physician : \_\_\_\_\_ 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 be 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.

\_\_\_\_\_  
Signature (Parent/Guardian/Adult Staff Member)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name (Parent/Guardian/Adult Staff Member)

\_\_\_\_\_  
Relationship to camper

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 or Camp Director 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

**THIS FORM REQUIRES PHYSICIAN'S SIGNATURE**  
**AND PARENT/GUARDIAN'S SIGNATURE**  
**FOR PRESCRIBED MEDICATIONS AND DAILY OVER-THE-COUNTER MEDICATION**

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. Daily Over the counter medication must also be in the original container.

**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 aid 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

Camper

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

Staff

**MEDICAL EVALUATION**  
**MUST BE GOOD WITHIN 2 YEAR OF CAMPER'S 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:

*(If you require a religious exemption for immunizations please contact our office at 860-974-1122)*

	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 Signature

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 these as needed over-the-counter medications.

**Symptom:**

**Over-The-Counter Medication:**

Athletes Feet  
Skin irritations  
Minor aches/pain/fever  
Minor cough/sore throat

Desenex or similar powder/spray  
Gold Bond Powder  
Tylenol/Advil/Ibuprofen/Aleve  
Robitussin/Cough/Throat Drops/Chloraseptic  
Throat Spray

Minor Allergic Reactions/Allergies  
Poison Ivy/Rashes  
Bug Bites

Benadryl, Claritin, Xyzel and Zyrtec  
Calagel Lotion/Calamine Lotion  
Benzocaine Swabs/Dermoplast  
Hydrocortisone Cream/Benadryl Cream  
Antacid/Pepto Bismol/Tums

Indigestion/Heartburn  
Constipation  
Clogged Ears  
Open Areas/Cuts  
Lactose Intolerant  
Sore Muscles

Milk of Magnesia  
Auro-Dry  
Bacitracin/Triple Antibiotic ointment  
Lactaid tablets  
Bengay (Menthol Muscle Pain relieving cream)

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

\_\_\_\_\_  
Signature of Parent or Legal Guardian

Date: \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Parent or Legal Guardian

Print Name of Parent or Legal Guardian \_\_\_\_\_

Parent's Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_