



family matters™

of GREATER WASHINGTON

1509 16th Street, NW, Washington, DC 20036 * (202)289-1510 * www.CampMossHollow.com

CAMPER APPLICATION SUMMER 2011

CAMPER INFORMATION

Camper Name: _____ Age: _____
 Home Address: _____ Apt: _____ Ward: _____
 City: _____ State: _____ Zip: _____ County: _____
 School: _____ Location: _____ Grade: _____
 GPA: _____ Date of Birth: ____/____/____ Shirt Size: _____ Gender: M / F
 Campers Email Address: _____ Camper Cell: _____

Please mark one of the following ethnic identities:
 American Indian/Alaska Asian American Black/African American White
 Native Hawaiian, Other Pacific Islander Hispanic/Latino Not Hispanic/Latino

PARENT INFORMATION

Custodial Parent/Guardian: _____
 Relationship to Camper: _____ Cell: _____
 Home: _____ Work: _____
 Email Address: _____
 Social Security #: _____ Total Family Income (Gross): \$ _____

Please mark the boxes that apply to you:
 TANF Medicaid Food Stamps Foster Parent

EMERGENCY CONTACT/AUTHORIZED PICKUP INFORMATION

My child may be picked up by the following authorized individuals (other than Parent/Guardian & Emergency Contact):

Emergency Contact 1: _____
 Relationship to Camper: _____
 Cell: _____ Home: _____
 Emergency Contact 2: _____
 Relationship to Camper: _____
 Cell: _____ Home: _____

Medical Coverage, provided by Family Matters of Greater Washington, for children attending camp, covers illnesses and injuries that occur during camp. It does not cover pre-existing conditions or extensive hospitalizations. Paying for conditions not covered remains the responsibility of the parent/guardian. A copy of the child's medical insurance must be submitted with this application.

Medical Insurance Company _____ Medical Insurance ID # _____
 Primary Care Physician _____ Physician Contact Phone _____

I/We grant permission for our child named above to take part in the Youth Development Programs provided by Family Matters of Greater Washington, D.C., Inc. I/We agree to assume all financial responsibility in case of injury or accident arising from such event(s). In case of injury or illness, I authorize FMGW staff to administer treatment.

Signature of Parent/Guardian _____

Date _____

For office use only:

REGISTRATION INFO

Registration Date: ____/____/____

Registered by: _____

Camp Brain: No: Yes:

Sessions Attending:

1 2 3 4 5
 6 7 8

Will you be attending open house:

Registration Fee: \$50
 (Non Refundable)

Session Tuition: \$ _____
 (There will be no refund on cancellations made within 3 weeks of expected arrival date. Payments are not refundable for no shows).

TOTAL DUE: \$ _____

Deposit Paid: \$ _____

Online Payment: \$ _____

Balance Due: \$ _____

Referring Agency _____

Coordinator _____

Phone _____

Parents complete

Date of last Immunization: _____

Hospitalized in the last 3 months:

No: Yes:

Reason: _____

List ALL Prescribed Medications:

1. _____
2. _____
3. _____
4. _____

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

Complete, sign and return the form to FMGW 1509 16th, St., NW Washington, DC 20036.
Please read the instructions. If you need help completing this form, call: 202-289-1510 x 1187

1. CHILD'S NAME: _____

Last	First	M.I.

2. Is this a FOSTER CHILD? (See the instructions). If this is a foster child, check here [] and write the child's monthly personal use income here: \$ _____. Go to section #5.

3. Are you getting FOOD STAMPS, TANF or FDPIR benefits for your child? List the CASE NUMBER. DO NOT complete section #4. Go to section #5.

Food stamp case number: _____ FDPIR case number: _____

TANF case number: _____

Are you enrolled in any other eligible subsidized benefit program? If so, write in the program and any identification number. _____

4. ALL OTHER HOUSEHOLDS: (Complete this part only if you did not complete sections #2 or #3) List all household members, including the child/children listed above. List all income. Go to section #5.

Names	Current Monthly Income			
	Names of Household Members (include the child listed above)	Monthly Earnings from Work (Before Deductions) Job 1	Monthly Welfare, Child Support, Alimony	Monthly Payments from Pensions, Retirement, Social Security
1.	\$	\$	\$	\$
2.	\$	\$	\$	\$
3.	\$	\$	\$	\$
4.	\$	\$	\$	\$
5.	\$	\$	\$	\$
6.	\$	\$	\$	\$
7.	\$	\$	\$	\$
8.	\$	\$	\$	\$
9.	\$	\$	\$	\$
10.	\$	\$	\$	\$
11.	\$	\$	\$	\$

**HOW TO COMPLETE THE SUMMER FOOD SERVICE PROGRAM
INCOME ELIGIBILITY FORM**

Please complete the Income Eligibility Form using the instructions below. Sign the form and return it to FMGW
1509 16th St., NW, Washington, DC 20036. If you need help, call this phone number:
202-289-1510 x 1187

1. CHILD INFORMATION:

(a) Print your child's name. If you have more than one child enrolled in this same summer program, please write each child's name on this form in the space provided.

2. FOSTER CHILDREN: Complete this Part and sign the form in #5.

- (a) Write the foster child's monthly "personal use" income. Write "O" if the foster child does not get "personal use" income.
- (b) A foster parent or other official representing the child must sign the form in #5. You do not have to list a social security number.
- (c) Complete a separate form for each foster child.

3. OTHER BENEFITS: Complete this Part and sign the form in #5.

- (a) List your current food stamp, FDPIR or TANF case number(s) for your child(ren).
- (b) A child that is enrolled as a participant in Even Start or Head Start (families that meet the low-income criteria), or a child or youth that is homeless or runaway is automatically eligible to receive meal benefits without completing this form or further eligibility determinations.
- (c) Sign the form in #5. An adult household member must sign. You do not have to list a social security number; however, if a social security number is not listed or an indication is not made that the adult household member signing the form does not have a social security number, we cannot approve the form.

4. ALL OTHER HOUSEHOLDS: Complete this Part and sign the form in #5.

- (a) Write the names of everyone in your household even if they do not have an income. Include yourself, your spouse, the child or children you are applying for and all other household members.
- (b) Write the amount of income each person received last month before taxes or anything else was taken out and where it came from, such as earnings, welfare, pensions, and other income (see the examples below for types of income to report). Each income amount should be entered in the appropriate column on the form. If any amount last month was more or less than usual, write that person's usual monthly income.
- (c) If anyone is self employed, write the amount of income the person earns from self-employment; for example, income from being a family day care home provider, or operating a farm. Please call the number at the top of the form if you need help.
- (d) Sign the form and include your social security number in #5. *If you do not have a social security number, write "none". Read #3 (d) above.*

5. SIGNATURE AND SOCIAL SECURITY NUMBER:

- (a) The form must have the **signature** of an adult household member.
- (b) The adult household member who signs the statement must include his/her **social security number**. *If he/she does not have a social security number, write "none" or check the box in #5 on the form that indicates you do not have a social security number.* A social security number is not needed if you listed a food stamp, FDPIR or TANF case number or if you are applying for a foster child.

6. RACIAL/ETHNIC IDENTITY: You are **not required** to answer this question to get meal benefits, but completion of this information will help ensure that everyone is treated fairly.

INCOME TO REPORT

Earnings from Work

Wages/salaries/tips
Strike benefits
Unemployment compensation
Worker's compensation
Net income from self-owned
business, day care business or farm

Pensions/Retirement/Social Security

Pensions
Supplemental Security Income
Retirement income
Veteran's payments
Social security

Other Monthly Income/Self-employment

Disability benefits
Cash withdrawn from savings
Interest/dividends
Income from estates/trusts/
investments
Regular contributions from persons not living
in the household
Net royalties/annuities/net rental income
Military allowance for off-base housing
Any other income

Welfare/Child Support/Alimony

Public assistance payments
Welfare payments
Alimony/child support payments

5. SIGNATURE AND SOCIAL SECURITY NUMBER:

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the food stamp, FDIPIR, TANF or other eligible program case number is current, correct or that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the Income Eligibility Form and that the deliberate misrepresentation of the information may subject me to Prosecution under applicable State and Federal laws.

Signature of Adult: _____

Social Security Number: _____ - _____ - _____ Check here if you do not have a social security number. (NOTE: if a social security number is not listed or an indication is not made that the adult household member signing the form does not have a social security number, we cannot approve the form.)

Printed Name: _____ Home Phone: _____

Work Phone: _____ Home Address: _____

City: _____ State: _____ Zip Code: _____ Date: _____

Privacy Act Statement: Unless you list the child's food stamp, FDIPIR or TANF case number or are applying for a foster child, Section 9 of the National School Lunch Act requires that you include the social security number of the household member signing the form or indicate that the household member signing the form does not have a social security number. You do not have to list a social security number, but if a social security number is not listed or an indication is not made that the adult household member signing the form does not have a social security number, we cannot approve the form. The social security number may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp, FDIPIR or TANF office to determine current certification for food stamps, FDIPIR or TANF benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The social security number may also be disclosed to programs as authorized under the National School Lunch Act and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain Federal, State and local education, health and nutrition programs.

6. RACIAL/ETHNIC IDENTITY: You are not required to answer these questions. If you choose to do so, please mark one of the following ethnic identities:

[] Hispanic or Latino [] Not Hispanic or Latino

Please mark one or more of the following racial identities:

[] American Indian or Alaskan Native [] Asian [] Black or African American [] Native Hawaiian or Other Pacific Islander [] White

"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 USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer."

For Official Use Only:

Food Stamp/FDIPIR/TANF or other eligible benefit program household categorically eligible free: [] Yes [] No

MONTHLY INCOME CONVERSION: WEEKLY X 4.33, EVERY 2 WEEKS X 2.15, TWICE A MONTH X 2

Total monthly income: _____ Household size: _____ Eligible: _____ NOT Eligible: _____

Eligibility Classification: Free ____ Reduced Price ____ Paid ____ Temporary: Free ____ Reduced Price ____

Determining official: _____

Signature: _____ Date: _____



Camp MossHollow

www.CampMossHollow.com

45 Years of Building Future Leaders Naturally

SUMMER REGISTRATION BEGINS

MARCH 1, 2011

2011 SESSION DATES

Session 1: Mon. June 27-July 1

Session 2: Tue. July 5-July 16-(filled)

Session 3: Mon. July 18-July 22

Session 4: Mon. July 25-July 29-(filled)

Session 5: Mon. Aug. 1-Aug. 5

Session 6: Sun. Aug. 7-Aug. 13-(filled)

Session 7: Mon. Aug. 15-Aug. 19

Open House at Camp Moss Hollow

June 24, 2011

from 10:00am - 1:00pm

Sign up for the Open House at Registration

Call (202)289-1510 x1187 to register by appointment
or go to www.CampMossHollow.com to register online.

Family Matters of Greater Washington

is a non-governmental, not for profit organization.

1509 16th Street NW Washington DC 20036


family matters™





CAMPER PROFILE SUMMER 2011

CAMPER PROFILE

Camper Name: _____ Nickname: _____

Child currently lives with: ___ Parents ___ Mother ___ Father ___ Grandparents ___ Other: _____

Age of Brother(s): _____ Age of Sisters(s): _____

Ever attended Camp Moss Hollow: No Yes

If yes, what years: Summer: _____

Winter: _____

What other overnight camps have you attended: _____

Camper characteristics (Please (X) all that describe your child):

- Alert Cheerful Selfish Friendly Tries to finish what they start
- Obedient Very active Bossy Moody Light Sleeper
- Shy Strong-Willed Easy-going Bully Bed Wetter
- Talkative Quiet Easily Led Sad Sleep Walker

Can child swim in deep water? No Yes

Family Status:

Unmarried Divorced Separated Married

How did you hear about Camp Moss Hollow?

Newspaper Radio Movie Theater Ad Face book Twitter Friend Camp Fair

ACA School Flyer School PTA Recreation Center Text Advertising

Other _____

Please write any additional information you feel important concerning your child: _____

CAMPER DIETARY PROFILE

My child does **NOT** require any special dietary needs.

My child does have special dietary needs as follows:

- Vegetarian meals ONLY No red meats No milk/dairy products
- No Peanut butter/nuts No wheat products No shell fish/seafood

Other dietary comments: _____



Parent Consent and Release of Liability 2011

It is agreed and understood that:

- ❖ Camp Moss Hollow (Camp) serves children from varied economic and ethnic backgrounds, and various physical and social abilities. The camper population is reflective of the youth and teen population in the Washington, DC metropolitan area.
- ❖ Camp Moss Hollow has a zero tolerance policy for drugs, alcohol, weapons or any physical or verbal behavior that causes physical harm or intimidation. Campers identified for any of these infractions will be sent home. It is agreed that the camp director reserves the right to reject applications and to dismiss a camper, if necessary, for the good of the camp.
- ❖ While the camp takes every reasonable precaution, it is agreed that the camp assumes no responsibility for the camper's personal property. We ask that campers not bring electronic equipment including cell phones and portable games to camp.
- ❖ I understand the camp encourages positive hygiene practices for all campers. Campers will take daily showers to promote good grooming. Camp staff, if needed will wash comb and style hair in the interest of health and hygiene. This is particularly important after swimming and hikes.
- ❖ Prior to Camper's participation in Camp activities, I acknowledge that involvement of Camper in Camp may involve risk of property damage and of personal injury, illness and even death of Camper, including but not limited to the risks arising from transportation-related activities, accidents in the outdoors and rustic facilities, adverse weather conditions, and injuries and illness as a result of food borne illness and allergic reactions. In addition, I understand that there may be other risks inherent in Camp activities of which I may not be presently aware. I understand that although the camp staff makes all efforts to ensure health and safety at all times, I am aware that all camp programs present risks and hazards, which the participant assumes. I hereby accept those risks associated with participation.
- ❖ I warrant that the Camper indicated on this page is fully capable of safely participating in all Camp activities and has my permission to participate in all camp-related activities and special programming including swimming, boating, hiking, sleep-outs in tents, and out-of-camp trips unless I notify Camp Moss Hollow otherwise in writing.
- ❖ I further recognize that I have instructed my child or ward, to the extent my child or ward will be attending and participating in activities at Camp Moss Hollow, in the importance of knowing and abiding by the rules, regulations and procedures at Camp Moss Hollow.

Consent to Attend Camp Moss Hollow

I hereby give permission for _____ to participate and attend Camp Moss Hollow.

Camper's Name: _____ Gender: _____ Age: _____

Attending Session(s): 1 2 3 4 5 6 7 8 Retreat Winter Camp

Print Parent or Guardian Name

Relationship to Child

Signature of Parent or Guardian

Date



Camper Medical Procedures SUMMER 2011

Camper's Name: _____ Age: _____ Gender: _____

Camp Medical Procedures

The camp follows a healthcare protocol, which is based on best practices by childcare professionals and reviewed and signed by a medical practitioner or licensed physician.

Every child must have a recent health examination (within six months of camp departure date) to attend camp. School based medical forms are acceptable if signed within this time period. However, **all** parents must complete a **Medical Update Form** that details any changes of address, parent contact or changes in the child's medical condition or prescribed medication. Your personal physician must complete all medical questions on the health history form-- **then sign and date the form**. Please bring your child's **immunization record** to the physical examination so that this information will be included on the signed medical form.

A trained medical practitioner is on duty at camp and can attend to minor camp related illnesses and injuries. On arrival day at camp, the camp medical staff will screen each child briefly. All medications will be turned over, at this time, to be recorded and kept safely in the Health and Wellness Center.

All medications must be labeled with your child's name and must be in its original container in order to be administered to your child.

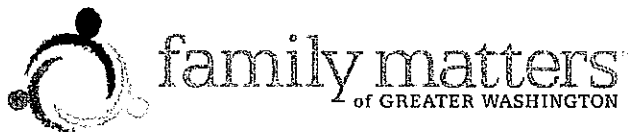
***Medications are documented against the child's medical form. Therefore, if the signed medical form indicates that your child is on medication, we are required to give that medication as indicated on the form. If your child does not have the medication indicated on the form, he/she cannot stay at camp unless you (the parent) bring the medication to camp prior to the scheduled dosage.**

Our local health authority prohibits the camp from administering non-prescription drugs, such as Tylenol, Chloroseptic, without written parent approval. **This signed Release serves as your approval.**

All children, who are on regular medication prior to their arrival at camp or during the school year, must remain on that medication while at camp. Many times, children who are withdrawn from their medication just prior to camp, experience physical and behavioral discomfort as a result.

If your child is injured (e.g. broken bone, burned), has an abrasion (e.g. fell off a bike) or has been exposed to a communicable disease just before attending camp, please contact the Youth Development Office immediately. We will be happy to try and reschedule your child for a different session. This is for the health and well being of all. Failure to notify us in advance may result in your child being sent home.

The camp has arranged for medical insurance to cover the normal camp related illnesses and injuries. It will not cover extensive hospitalization, major medical expenses or pre-existing medical conditions. Conditions not covered by the camp policy, or those that exceed the limits of the camp policy shall remain the responsibility of the parent or guardian.



1509 16th Street, NW, Washington, DC 20036 * (202)289-1510 * www.CampMossHollow.com

Camper Medical Release SUMMER CAMP 2011

The following statements do not affect your child's eligibility for camp. Special medical needs are considered on a case-by-case basis to ensure a successful experience for your child.

1. This Camper Release authorizes the camp to administer non-prescription drugs unless indicated and prohibited on their health form. If the nurse should have any questions about dosage, times, etc., he/she will contact the parent at the number indicated above.

Parent/Guardian Signature: _____ **Date:** _____

2. It is agreed that in case of injury or illness, I authorize my child to receive treatment by an emergency medical technician, camp nurse, hospital, dentist or doctor. First aid may be given at camp. Any follow-up medical attention may be given at a local hospital. Transportation to the nearest hospital is authorized if necessary. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to hospitalize and secure proper treatment for my child.

Parent/Guardian Signature: _____ **Date:** _____

3. It is agreed that my child's medical insurance is the primary coverage of any illness or injury sustained while at camp. It is understood that Family and Child Services of Washington, DC Inc., may elect to cover illnesses and injuries under their medical insurance to the maximum limitation of the coverage. It is agreed that I will have my child's medical insurance carrier to make contact with Family and Child Services of Washington, DC, Inc., medical carrier for transfer of responsibility. It is clearly understood that if my child does not have proper medical insurance that all costs occurred from my child's illness or injury is my responsibility.

Parent/Guardian Signature: _____ **Date:** _____

4. It is agreed that if my child is on regular medication prior to their arrival at camp or during the school year, they must remain on that medication while at camp

Parent/Guardian Signature: _____ **Date:** _____

5. I further understand that Camp Moss Hollow, by law, cannot assist in administering prescription drugs to my child, even with parental consent, unless the medication is sent in its properly labeled original container with medical verification and the administrative instructions clearly printed with the child's name. Any revised or makeshift labels or containers will not be accepted and will result in your child being sent home for his/her medical well being.

Parent/Guardian Signature: _____ **Date:** _____

6. Finally, if any recorded medication has changed since the child's registration, I agree to update their medical file prior to camp departure by a licensed physician. I agree to send all medications for asthma, allergies, etc. to cover the length of the session. In the event that this is not done, I understand that my child may be sent home for his or her medical well being.

Parent/Guardian Signature: _____ **Date:** _____



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Photo Release for Person Under 18 Years of Age SUMMER 2011

I hereby grant Camp Moss Hollow and Family Matters of Greater Washington and its employees, agents, assigns, and sponsors the right to photograph and/or video tape my child for use in promotional or educational materials as follows photo and/or video footage and or other digital reproduction of him/her or other reproduction of his/her physical likeness for publication processes, whether electronic, print, digital or electronic publishing via the Internet.

Print Name of Camper: _____

Address: _____

City: _____ State: _____ Zip: _____

Yes

No

My child is a foster child

I hereby authorize the use of these materials indefinitely without compensation. All negatives or positives, prints, digital reproductions and video, audio recordings or quoted remarks shall be the sole property of Camp Moss Hollow and Family Matters of Greater Washington

I certify that I am the custodial parent and/or guardian and have the aforementioned rights to assign.

Signature of Parent or Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Date: _____

For Office Use

Health History and Examination Form for Children, Youth and Adults Attending Camps

FM 08N

Suggested for resident camp use.

Developed and approved by
American Camping Association®
American Academy of Pediatrics

Dates of Camp Attendance _____

Mail this form to the address below by 05/31/11 (date)
FMGW / Camp Moss Hollow
1509 16th St., NW.
Washington, DC 20036
202-518-8926 Fax

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians of minors or by adults themselves.

Update required annually. Health exam (back page) must be completed by approved licensed medical personnel at least every two years.

Year

Name _____ Birth date _____ Age at camp _____
Last First Middle

Home address _____
Street Address City State Zip

Social security number of participant _____ Gender: Male Female

Custodial parent/guardian _____ Phone _____

Home address _____
(if different from above) Street Address City State Zip

Business address _____ Phone _____
Street Address City State Zip

Second parent or guardian or emergency contact _____

Address _____ Phone _____
Street Address City State Zip

Business address _____ Phone _____

If not available in an emergency, notify _____

Relationship _____ Phone _____

Address _____
Street Address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____

► Photocopy of front and back of health insurance card must be attached to this form.

Important — These boxes must be complete for attendance*

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal

representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer _____

Printed Name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer _____ Date _____

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

Cabin or Group

Name

Health History

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the

completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known.

Describe reaction and management of the reaction.

Medication allergies (list)

_____	_____
_____	_____
_____	_____

Food allergies (list)

_____	_____
_____	_____

Other allergies (list) — include insect stings, hay fever, asthma, animal dander, etc.

_____	_____
_____	_____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. 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.

This person takes NO medications on a routine basis.

This person takes medications as follows:

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 _____

Attach additional pages for more medications.

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

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

Does not eat red meat

Does not eat pork

Does not eat eggs

Does not eat poultry

Does not eat seafood

Does not eat dairy products

Other (describe) _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

General Questions (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			
16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions.

Which of the following has the participant had? <input type="checkbox"/> Measles <input type="checkbox"/> Chicken pox <input type="checkbox"/> German measles <input type="checkbox"/> Mumps <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C TB Mantoux Test Date of last test _____ Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Please give all dates of immunization for: 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) _____
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Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. (ACA accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions

Recommendations and Restrictions at Camp

Treatment to be continued at camp _____

Medications to be administered at camp (name, dosage, frequency) _____

Any medically-prescribed meal plan or dietary restrictions _____

Known allergies _____

Description of any limitation or restriction on camp activities _____

Additional information for health care staff at the camp _____

Signature of Licensed Medical Personnel _____
Printed _____ Title _____
Address _____
Phone _____ Date _____

For camp use only

Screening Record
Date screened _____ Time _____ am
pm
Meds received _____
Updates/additions to health history noted Yes No None required
Current health needs identified _____
Observational notes _____
Screened by _____



Things to Bring to Camp SUMMER CAMP 2011

A duffel bag will hold all you need and tow well on the bus and under your bed. Be sure that your child's name is on all possessions. Here's what is needed this summer:

Sleep Wear

- 1 Sleeping bag or 2 single sheets and 1 blanket
- 2 pair of pajamas

Toiletries

- 2 – 3 towels and washcloths
- 1 travel size deodorant, lotion, hair grease and powder
- 1 Bar soap or Shower gel
- 1 brush or comb
- 1 toothpaste and toothbrush
- 1 pair of shower slippers
- 2 small trash bags for dirty clothes

Clothes

- 1 light jacket for cool evenings
- 1 long sleeve shirt
- 1 sweatshirt
- 2 plain white tee shirts
- 4 or more tee shirts or short-sleeved shirts
- 1 lightweight raincoat or poncho (with hood, if possible)
- 1 cap or scarf for hikes
- 5 or more pairs of socks
- 2 swimsuit / trunks
- 1 pair of casual / dress shoes for evening program
- 1 pair of sneakers
- 1 pair of hiking boot (if possible)
- 4 pair of shorts
- 2 – 3 pair of long jean pants
- 1 dress or skirt and top (girls) for evening program
- 1 pair of slacks and shirt (boys) for evening program

Extras

- 1 flashlight (extra set of battery)
- Bug repellent
- Small pillow

Please don't bring all new clothes or sneakers. We hike in the rain and play in the mud. We sit on the ground and exercise on the floor. Come prepared to get dirty and have some fun. Bring practical, comfortable clothes and shoes. Remember there may be some cool days and nights. It is important that each child's belonging be clearly marked with his/her name.

