



Fresh Air Camp - 2010 Application



1010 Harrison Avenue, Boston, MA 02119

Phone: 617-541-1253 Fax: 617-541-1408 Email: youthinfo@goodwillmass.org

CAMPER INFORMATION:

Camper Name: _____ Male Female
 Nickname (if applicable) _____ DOB: _____ Age: _____
 School: _____ Grade: _____
 Address: _____
 Home tel.: _____

CUSTODIAL PARENT/GUARDIAN:

Name: _____
 Relationship: _____
 Address: _____

 Home tel.: _____
 Work tel.: _____
 Cell #: _____

PARENT/GUARDIAN:

Name: _____
 Relationship: _____
 Address: _____

 Home Tel.: _____
 Work Tel.: _____
 Cell #: _____

EMERGENCY CONTACTS: Emergency contact information **MUST** be different than the guardian information and include relationship to child. For example: grandparent, aunt, uncle, neighbor. At least three emergency contacts are required.

Name: _____ Relationship: _____
 Tel: Home: _____ Work: _____ Cell: _____
 Name: _____ Relationship: _____
 Tel: Home: _____ Work: _____ Cell: _____
 Name: _____ Relationship: _____
 Tel: Home: _____ Work: _____ Cell: _____

AGENCY REFERRAL INFORMATION:

Agency Name: _____
 Telephone: _____
 Contact: _____
 Address: _____

SESSION SELECTION INSTRUCTIONS

Campers may attend one session, and may request to be on a wait list if space becomes available for additional sessions.

PLEASE WRITE #1 FOR YOUR FIRST CHOICE, #2 FOR YOUR SECOND CHOICE.

___ SESSION ONE: JUNE 27 - JULY 8	___ SESSION TWO : JULY 11 - JULY 22
___ SESSION THREE: JULY 25 - AUGUST 5	___ SESSION FOUR: AUGUST 8 – AUGUST 19

ACCEPTANCE POLICY: Please print clearly. Completed applications are processed only when all portions are complete and a \$50 deposit has been made. Applicants will be notified within 5 business days. Goodwill reserves the right to deny acceptance to Camp Application(s) subject to document review, interview and/or lack of payment.

1	2	3	4
Custodial Parent's Last Name _____			
Fee per session _____ Total fee _____ Confirmation mailed _____			
Billing Agency _____ Fee approved _____			
Name of Agency Contact/Approved by _____			
Billing Address/ Tel. _____			
Household Income/member(s) _____			
Discharge Date _____ COMMENTS:			
FOR CAMP OFFICE USE ONLY ENTERED ETO by: _____			



Goodwill Fresh Air Camp Agreements and Releases



PARENT/GUARDIAN

Name of Parent/Guardian (Person who is authorized to sign these agreements and releases):

Name of Camper:

NO REFUND POLICY

*****PLEASE READ CAREFULLY*****

I understand that once my child has been accepted to camp there are NO refunds for camp fees, deposits, lost or stolen property, if my child is sent home for a disciplinary reason or is unable to attend as scheduled.

X

Signature/parent/guardian /date

TRANSPORTATION AGREEMENT

I acknowledge that it is the responsibility of the parent/guardian to approve arrangements for my child's transportation to and from Goodwill Fresh Air Camp. My child may be released to me OR

Insert name, address, telephone of one other person.

Insert name, address, telephone of one other person.

Insert name, address, telephone of one other person.

PHOTOGRAPH RELEASE

YES NO My child may be photographed for pictures to be used for publicity or fundraising reasons. This consent is valid for one year from date of signature.

X

Signature/parent/guardian /date

EVENT AND TRIP RELEASE

YES NO My child may attend events and field trips while at Camp. If no, you must indicate in writing to the Director which events/trips your child may not attend while at Camp.

X

Signature/parent/guardian /date

MEDICAL EMERGENCY RELEASE AND AGREEMENT

I give my permission for medical or dental care to be administered to my child in the event of an emergency and/or for medications prescribed by a physician to be administered by the Camp Staff while my child is in attendance at Goodwill Fresh Air Camp. In the event of an emergency, I will be notified at once. In the absence of insurance, I agree to pay all charges.

X

Signature/parent/guardian /date

RELEASE OF LIABILITY

The applicant named below has applied to participate in the Fresh Air Camp, which is operated by Morgan Memorial Goodwill Industries ("Goodwill"). I am the applicant's parent or guardian.

In consideration of Goodwill's acceptance of the applicant as a camper, I hereby release and hold harmless Goodwill, its officers, trustees, employees, and agents, from any and all liability, loss or damage arising from the applicant's attendance at the Fresh Air Camp, including, without limitation, the applicant's participation in any of the programs or activities offered by the Fresh Air Camp or by Goodwill.

I have read this release, or have had this release read to me. I fully understand, and voluntarily agree to this release.

Name of camper applicant

X

Signature/parent/guardian /date



Goodwill Fresh Air Camp Camper Profile



Camper's Name: _____ **Parent's/Guardian's Name:** _____

Directions:

The information requested on this page is designed to offer an opportunity to understand your camper. Your answers will assist Camp Staff in determining appropriate placement of your camper. All camper profiles are confidential and will be handled by the appropriate Goodwill Staff.

An application cannot be processed unless the camper profile is completely filled out and signed.

Under each question, circle all answers that apply.

1. My child is:
 - a. My biological child
 - b. A foster child
 - c. An adopted child
 - d. My grandchild
 - e. Other: _____

2. Has your child experienced a traumatic event in the past two years?
 - a. Serious illness of a family member
 - b. Loss of a family member
 - c. Loss of a friend
 - d. Violence
 - e. Other: _____

3. My child has:
 - a. A sibling/relative who will also attend camp
 - b. Name/Relationship _____
 - c. Attended Fresh Air Camp in summer of _____
 - d. Attended BNY Mellon Academy for Girls in year(s) of _____
 - e. Participates in the GoodGuides Mentoring Program.

4. My child has been involved with the following Government agencies:
 - a. Department of Social Services
 - b. Department of Youth Services
 - c. Other: _____

5. My child is:
 - a. Happy to go to camp
 - b. A little apprehensive about going to camp
 - c. Very apprehensive about going to camp

Please check all that apply to your child:	Never	Rarely	Most of the time	Always
Has had difficulty in school				
Listens to others without interrupting				
Enjoys reading				
Enjoys math				
Enjoys science				
Becomes withdrawn in social settings				
Accepts responsibility for his/her actions				
Actively seeks help for support when needed				
Follows the rules				
Resolves conflict with force				
Is able to stay focused and finish projects				
Experiences bed wetting				
Has your child had more than 5 significant absences from school in the current school year?	YES <input type="checkbox"/>		NO <input type="checkbox"/>	
If Yes, explain:				

Make additional comments in the space provided below: (Please do not include health care information on this page).

X _____
Signature/parent/guardian/date



Goodwill Fresh Air Camp



Application will be processed only if all parts are completed and signed, and application fee has been submitted.

All final payments and documentation must be received 3 weeks prior to departure; failure to comply will result in forfeiture of payments and camper slot.

APPLICATION AND REQUIRED ATTACHMENT CHECKLIST

- _____ \$50 APPLICATION FEE PER CHILD, PER SESSION is required for your application to be reviewed. **The application fee is non-refundable and will only be returned if a child is not accepted.** Once your child has been accepted, this fee will be applied as a deposit toward camp tuition. ONLY if a child is not accepted to the Goodwill Fresh Air Camp will the application fee be returned. Application fee is attached.
- _____ Information on Page 1 is complete; session preferences are clearly indicated.
- _____ Emergency contact information other than parent/guardian is provided.
- _____ Photocopy of health insurance card is attached.
- _____ Agreements and Releases form contains all necessary information, signatures and dates.
- _____ Camper Profile has been completed and signed.
- _____ The "Application for Free and Reduced Price Meals" is complete including the TAFDC number or Social Security number. Food applications must be submitted even if the family does not qualify for this program.
- _____ To qualify for scholarship consideration, income verification information must be attached. A current tax return (W2), award letter, or 3 consecutive payroll stubs are acceptable.
- _____ Photocopy of camper's most recent school report card is attached.

Note: The required health form and attachments are due 3 weeks prior to departure. You may attach records to the health form.

Please direct all application communication to:

Goodwill Fresh Air Camp
 1010 Harrison Avenue
 Boston, MA 02119
 Attention: Camp Office
 Phone: 617-541-1253 Fax: 617-541-1408
 Email: youthinfo@goodwillmass.org

Massachusetts Department of Public Health: License to Operate a Residential Camp. Per 430.190: The Fresh Air Camp must comply with regulations of, and be licensed by, the Athol MA Board of Health. 105 CMR 430.000: MINIMUM SANITATION AND SAFETY STANDARDS FOR RECREATIONAL CAMPS FOR CHILDREN (STATE SANITARY CODE, CHAPTER IV). Parents may request copies of background check, health care and discipline policies as well as procedures for filing grievances. Please note: The health care and discipline policies as well as procedures for filing grievances are included with this packet under Camp Policies, Health Care Policies and Code of Conduct. Copies of background checks are maintained at Morgan Memorial Goodwill Industries, 1010 Harrison Ave., Boston, MA 02119: Human Resources Department.

Equal Opportunity Statement: Goodwill's Fresh Air Camp participates in the USDA Summer Food Program. Meals are available to eligible children without regard to race, color, national origin, sex, age, or disabilities.

MORGAN MEMORIAL FRESH AIR CAMP SLIDING SCALE FEE FOR 2010

Family Size including adults	Gross income under	Gross income under	Gross income under	Gross income under	Gross income under	Gross income under
2	\$23,961.00	\$34,230.00	\$47,922.00	\$61,614.00	\$71,883.00	\$89,854.00
3	\$30,051.00	\$42,918.00	\$60,085.00	\$77,274.00	\$90,153.00	\$112,691.00
4	\$36,141.00	\$51,630.00	\$72,282.00	\$92,934.00	\$108,423.00	\$135,529.00
5	\$42,231.00	\$60,330.00	\$84,462.00	\$108,594.00	\$126,693.00	\$158,366.00
6	\$48,321.00	\$69,030.00	\$96,642.00	\$124,254.00	\$144,963.00	\$181,204.00
7	\$54,411.00	\$77,730.00	\$108,822.00	\$139,914.00	\$163,233.00	\$204,041.00
8	\$60,501.00	\$86,430.00	\$121,002.00	\$155,574.00	\$181,503.00	\$226,879.00
for each additional child add	\$6,090.00	\$7,830.00	\$9,570.00	\$12,180.00	\$13,050.00	\$13,920.00
Camp Tuition Fee	\$125.00	\$175.00	\$300.00	\$500.00	\$625.00	\$750.00

A \$50 deposit is required to process the application fee.
 This fee is deducted from your Camp Tuition Balance once your child has been accepted into a session
 We can accept Checks and Money Orders (made out to Morgan Memorial Goodwill) by mail
 We accept Cash, Checks or Money orders in person at the Camp Office

Registrar hours:
 Monday, Tuesday, Wednesday 9 am to 5 pm
 Thursday and Friday 10am to 6 pm

Phone (617-541-1289)

mparrilla@goodwillmass.org

**HOW TO COMPLETE THE SUMMER FOOD SERVICE PROGRAM
MEAL BENEFIT INCOME ELIGIBILITY FORM
(For Camps and Closed Enrolled Sites)**

Please complete the following form using the instructions below. Sign the form and return it to: Goodwill

If you need help, call: (617) 541-1253

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

Part 1: List participant's name and a Food Stamp, TANF or FDPIR case number.

Part 2: Skip this part.

Part 3: Skip this part.

Part 4: Sign the form. A Social Security Number is not necessary.

Part 5: Answer this question if you choose to.

If you are applying on behalf of a FOSTER CHILD, use a separate application for each foster child and follow these instructions:

Part 1: Enter the child's name.

Part 2: Please contact us at: (617) 541-1253

Part 3: Skip this part.

Part 4: Sign the form. A Social Security Number is not necessary.

Part 5: Answer this question if you choose to.

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

Part 1: List each participant's name.

Part 2: Skip this part.

Part 3: Follow these instructions to report total household income from last month.

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

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

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

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

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

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

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

Part 4: An adult household member must sign the form and list his or her Social Security Number, or mark the box if he or she doesn't have one.

Part 5: Answer this question if you choose to.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

**SUMMER FOOD SERVICE PROGRAM
MEAL BENEFIT INCOME ELIGIBILITY FORM
(For Camps and Closed Enrolled Sites)**

Part 1. Children enrolled in Camp or Closed Enrolled Sites. (Use a separate application for each foster child)	
Names (First, Middle Initial, Last)	Food Stamp, TANF or FDPIR case # (if any). Skip to Part 4 if you listed a case #.

Part 2. Foster Child
In certain cases, foster children are eligible for free and reduced-price meals regardless of household income. If foster children live with you, please contact [name of Sponsor] at [phone number]. Skip to Part 4.

Part 3. Total Household Gross Income—You must tell us how much and how often					
A. Name (List everyone in household, including children) (Example) Jane Smith	B. Gross income and how often it was received Example: \$100/monthly \$100/twice a month \$100/every other week \$100/weekly				C. Check if NO income
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement,	4. All Other Income	
	\$200/weekly	\$150/weekly	\$100/monthly	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>

Part 4. Signature and Social Security Number (Adult must sign)
An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)
I certify that all information on this form is true and that all income is reported. I understand that that this information is being given for the receipt of Federal funds. I understand that SFSP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.
Sign here: X _____ Print name: _____ Date: _____
Address: _____ Phone Number: _____
Social Security Number: _____ I do not have a Social Security Number

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

Mark one ethnic identity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Mark one or more racial identities: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
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Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12
Total Income: _____ Per: Week, Every 2 Weeks, Twice A Month, Month, Year
Household size: _____
Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free ___ Reduced ___ Denied ___
Reason: _____
Temporary: Free ___ Reduced ___ Time Period: _____ (expires after ___ days)
Determining Official's Signature: _____ Date: _____
Confirming Official's Signature: _____ Date: _____
Follow-up Official's Signature: _____ Date: _____

**SUMMER FOOD SERVICE PROGRAM
MEAL BENEFIT INCOME ELIGIBILITY FORM
(For Camps and Closed Enrolled Sites)**

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

Non-discrimination Statement: In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to *USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington DC 20250-9410* or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

CAMPER HEALTH HISTORY FORM 1

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

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

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

Camper Name: _____
First Middle Last

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

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(s): _____ 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 has special food needs. *(Please describe below.)*

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 _____ Insurance Company 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

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

Has/does the camper:

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

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

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 _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last

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

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)
- Chlorpheniramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimate)
- 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 last 24 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: _____

Camper Name

First

Middle

Last

(For Camp Use) Cabin or Group

(For Camp Use) Session Code(s):