Camper Information

Child's Name:_____ Date of Birth:_____ Age:_____
Child's Home Address: _____City:_____ State:_____ Zip Code:_____
Primary Language:_____Gender: Male ☐ Female ☐

- An updated physical and immunization record **MUST** be attached along with the camp application, if not the application will NOT be processed. List of required immunizations below

DTaP/Tdap	**5 doses;** 4 doses are acceptable if the fourth dose is given on or after the 4th birthday; DT is only acceptable with a letter stating a medical contraindication to DTaP
Polio	**4 doses;** fourth dose must be given on or after the 4th birthday and ≥6 months after the previous dose or a fifth dose is required; 3 doses are acceptable if the third dose is given on or after the 4th birthday and ≥6 months after the previous dose
Hepatitis B	**3 doses;** laboratory evidence of immunity acceptable
MMR	**2 doses;** first dose must be given on or after the 1st birthday, and second dose must be given ≥28 days after first dose; laboratory evidence of immunity acceptable
Varicella	**2 doses;** first dose must be given on or after the 1st birthday and second dose must be given ≥28 days after first dose; a reliable history of chickenpox* or laboratory evidence of immunity acceptable

Parent/Guardian Information

Name:	Name:
Relationship to child:	Relationship to child:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone: Ext:	Work Phone: Ext:
Email:	Email:

Authorized Pick-up/Emergency Contacts (in addition to parent/guardians)

Name:	Name:
Relationship to child:	Relationship to child:
Cell Phone:	Cell Phone:
Work Phone: Ext:	Work Phone: Ext:

Medical Information

Health Insurance Company:_____
Name of Policy Holder:_____ Policy Number:_____
Allergies:_____
Special dietary, limitations or concerns? _____

Allergies

Type of Allergy: _____
Please explain reaction and severity:_____
Medications for above allergies:_____

Medications

Will your child be bringing any medications (including over the counter medications) to camp? **Yes**_☐_**No**_☐_
If "**Yes**", please complete a Medication Information Form on next page.

An Individual Healthcare Plan MUST be completed by a physician for children with chronic health conditions.

Acknowledgment of Risks and Waivers

_☐_I authorize the summer camp staff who are trained in the basics of First Aid/CPR to give my child First Aid/CPR when appropriate.

_☐_I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if in the event of injury, or should emergency care be required and I cannot be reached, I authorize camp staff to secure the necessary medical treatment.

_☐_ I give consent for photographs, video records of my son/daughter to be used by Winchester Recreation for publicity purposes..

I have read the above and agree with the policy and procedures as stated above.

_____ _____

Parent signature **Date**

Medication, Epi-Pen®, and Inhaler Administration Form

To be completed for any or all medications that will be brought to and administered at camp.

Please Read: Prescribed medications must include the pharmacy label with the Rx number, the name of the medication, dosage, directions for use, and the prescribed name. Non-prescription medications must be in their original containers, clearly labeled with the child's name and directions for use. All medications must be kept in the designated area. Please complete the following information regarding the appropriate times and dosages of each medication your child will receive at camp. (attach additional forms if needed). Please sign at the bottom of the page.

Name of Medication #`1:

Why is this medication taken?

Days Taken M ☐ T ☐ W ☐ Th ☐ F ☐ As needed ☐

Times Taken (be specific)_____ AM ☐ PM ☐ Other_____ Dosage_____

Are there any additional notes or instructions for this medication?

Name of Medication #2

Why is this medication taken?

Days Taken M ☐ T ☐ W ☐ Th ☐ F ☐ As needed ☐

Times Taken (be specific)_____ AM ☐ PM ☐ Other_____ Dosage_____

Are there any additional notes or instructions for this medication?

Type of Inhaler:

Location of Inhaler at camp
Health center or designated secure storage ☐ on campers person ☐ with camp counselor ☐

Who can administer inhaler?
Qualified Personal ☐ Camper ☐

Type of Epi-Pen®:

Location of Epi-Pen® at camp
Health center or designated secure storage ☐ on campers person ☐ with camp counselor ☐

Who can administer Epi-Pen®?
Qualified Personal ☐ Camper ☐

I hereby give permission for the Winchester Recreation Department to administer the above medications to my child or during his or her camp attendance.

Parent/Guardian Signature_____ **Date**_____

Camper Profile Questions

Please take time to answer some questions that will help our staff create a positive camp experience for your child.

What are your child's interests/favorite activities at school and at home?

Does your child have any characteristics that require special attention?

Does your child have any limitations or restrictions on camp activities? If yes, please explain.

Do you have any behavior management suggestions for your child?

What types of things can easily upset your child/cause them anxiety?

Do you have any other suggestions for how camp can provide the best experience possible for your child?