❑ Eligible ❑ Not Eligible
Camp Use Only

Corps:

Last Name, First Name:

CAMP CONNRI

Est. 1979

ACCREDITED

Camper Application

CAMPER INFORMATION

Camper Name: _____

Birthdate: _____ **Age:** _____ **Gender: Male ❑ Female ❑**

Address: _____ **Home Phone:** _____

_____

City/State: _____ **Zip:** _____

❑ **Is this your 1st time at Camp CONNRI?** **Camper T-shirt size:** _____

PARENT INFORMATION

Parent/Guardian Name(s): _____ **Relationship:** _____

Address (if different from above): _____ **Home Phone:** _____

_____ **Work Phone:** _____

City/State: _____ Zip: _____ **Cell Phone:** _____

Email: _____

EMERGENCY CONTACTS

(other than Parent/Guardian)	RELATIONSHIP:	HOME PHONE:	WORK PHONE:	CELL PHONE:

Please list any additional adults authorized to pick up camper. *Only those listed here and above will be able to pick up your child

_____

_____

UNIT USE ONLY

Check Camp Choice

❑ Session 1: Olympic Sports Camp (ages 13-16 only)	Mon June 27 - Fri July 1
❑ Session 2: Jurassic (Dinosaur) Camp	Mon July 4 - Fri July 8
❑ ~~Session 3: Music Camp~~	~~Mon July 11 - Fri July 15~~
❑ Session 4: Lego | STEM Camp	Mon July 18 - Fri July 22
❑ Session 5: Color Wars Camp	Mon July 25 - Fri July 29
❑ Session 6: Fear Factor Camp	Mon Aug 1 - Fri Aug 5

CORPS: _____

CORPS CONTACT:	WORK PHONE:	CELL PHONE:

Parents/Guardians,

Camp CONNRI wants to connect with you and has established a Facebook page for parents to enjoy their child's camping experience too! Each week Camp CONNRI will post a newsletter describing some of the activities of the week. Photos will be uploaded and shared daily so parents can see what their camper is experiencing at camp. In addition, parents can send their child a note through our Facebook page or email, campconnri@gmail.com and we will deliver it to your child! If time permits your child will be given the opportunity to respond sending you a special note and picture. If you would like to participate in this program, please sign in the space below. Camp CONNRI looks forward to letting you share in your child's camping experience!

- ❑ **YES! I want to experience camp with my child: _____**
- ❑ **NO, please do not include my child: _____**

Camper Behavioral Expectation:

At Camp CONNRI it is our mission to demonstrate the love of God to all campers, and we will do everything possible to ensure that they have a safe and positive camping experience. For this to happen, your child needs to understand that will they are under our supervision, they must abide by our rules and guidelines, since we are responsible for their well-being the same way a parent/guardian would be. When inappropriate behavior occurs, every effort will be made by the Camp CONNRI staff to redirect camper behavior and to help find ways to resolve behavior problems. If our efforts do not lead to improved behavior, we will contact you (*a warning will be given to the camper*). If after contacting you your child's behavior still does not improve, your child may be dismissed from camp (*please note that certain behavior may lead to immediate dismissal*). In the event that your child is dismissed from camp, we will contact you, and you will be responsible for arrangement to pick up your child. *If a camper vandalizes, damages, or otherwise destroys any camp equipment and/or supplies, you will be held responsible and may be required to pay for the repair/replacement of such items, at the discretion of Camp CONNRI.

Camper Statement—RESPECT:

- ☺ I will **respect God** by participating in activities and lessons that teach me about Him.
- ☺ I will **respect staff** by doing what they ask me to do without arguing or complaining
- ☺ I will **respect other campers** by being nice to them, and will not be rude to them, make fun of them, bully them, or touch anything that belongs to them.
- ☺ I will **respect nature** by being kind to animals, protecting their environment, and also not throwing trash where it doesn't belong.
- ☺ I will **respect camp property*** by taking care of all equipment and facilities, and will not break, steal or damage anything at camp. I also understand that I must keep my cabin clean.
- ☺ I will not use rude or foul language.
- ☺ I will make friends at camp, but I will not have romantic relationships with other campers or staff.
- ☺ I understand that if I have a problem at camp, or if someone does something to me, I should not try to take care of it myself, but I should tell my counselor. If he or she cannot help me, I can speak to the Chief Counselor, the Intervention Counselor, or Camp Director.

Camper Signature: _____ Date: _____

Please read through and sign off on the following:

1) I assume all monetary responsibility for prescriptions, doctor and/or hospital visit(s) for any treatment not directly related to attendance at Camp CONNRI for my child.

2) If my child is unable to continue at camp due to medical or behavioral issues, I will be responsible for the timely removal of my child from camp.

3) I understand that my child will not be able to contact me while at camp, except via the CONNRI Facebook page, and cell phones are not allowed. I am encouraged to write letters and only call in an emergency.

4) I hereby give permission for my child to participate in all activities (including swimming, athletics and challenge courses) unless a doctor has indicated any medical conditions that would prohibit them on the attached medical form.

Parent Signature: _____ Date: _____

Camp CONNRI
28 Happy Hill Lane
Ashford, CT 06278
Phone: (860) 429-6401
Email: campconnri@gmail.com
Web:https://campconnri.org
Facebook: https://www.facebook.com/CampCONNRI

Additional Information Form

The following information will assist us in planning your childs camp experiences.

Camper Name:_____

Sessions:_____

Interests:

Activities which your child enjoys:	☐ Music ☐ Arts & Crafts ☐ Nature/Pioneering ☐ Archery ☐ Swimming ☐ Sports/Group Games ☐ Rockwall
Activities which your child avoids:	
Does your child enjoy playing with other children?	
How does your child react to limit setting or frustration?	

Personality:

Describe your child's personality.
Briefly describe your child's responses to & attitude towards adults in authority?
Briefly describe any changes in your family—separation, divorce, marriage, birth, death, relocation.
What are your child's hopes for their camp experience?

Concerns:

☐ Fears or Phobias	☐ Stealing
☐ Destructiveness	☐ Running Away
☐ Temper Tantrums	☐ Nightmares
☐ Eating Disorders	☐ Soiling
☐ Aggressive Behavior	☐ Homesickness

Treatment:

Has your child been seen by a:
☐ Counselor ☐ Psychiatrist ☐ Psychologist
If currently seen by one of the above, what are the present goals of the treatment plan:
☐ Currently not seeing one of the above

Other Information:

Is there any other pertinent information that you feel is necessary to share with the camp administration to assist us in providing a quality camp experience for your child?

Permissions:

Please refer to the Parent Guide regarding our camp activities.

☐ I give my camper permission to participate in all activities offered at Camp CONNRI during their week at camp.

☐ I give my camper permission to participate in all activities offered at Camp CONNRI except the following:

_____

Release of Information

I hereby permit The Salvation army to release this information to camp CONNRI for use in program planning and placement of my child.

Signed:_____ **Date:**_____

For Intervention Counselor Use Only

2021-22 Application for Free and Reduced-price School Meals or Free Milk

Camper Name: ____________________

Complete one application per household. Please use a pen (not a pencil).

STEP 1 List ALL Household Members who are infants, children and students up to and including grade 12. (If more spaces are required for additional names, attach another sheet of paper.)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in **Foster care** and children who meet the definition of **Homeless** or **Runaway** are eligible for free meals. Read **How to Apply for Free and Reduced-price School Meals** for more information.

Child's First Name	MI	Child's Last Name	School	Grade	Student? Yes	Student? No	Foster	Head Start	Homeless or Runaway
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐

Check all that apply (Foster, Head Start, Homeless or Runaway)

STEP 2 Do any household members (including you) currently participate in one or more of the following Assistance Programs – SNAP or TFA? (This does NOT include medical (HUSKY) benefits).

If NO, > Go to STEP 3

If YES, a household member does participate in SNAP or TFA, write a SNAP OR TFA case number here and then go to STEP 4 (*Do not complete STEP 3.) To quicken the approval process, it is strongly recommended that you submit proof of SNAP or TFA eligibility with this application. See instructions.*

Case Number: Go to Step 3

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered "Yes" to Step 2)

Are you unsure what income to include here?

Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with the All Adult Household Members section.

A. Child Income

Sometimes children in the household earn income. Please include the TOTAL income earned by all Child Household Members listed in STEP 1 here.

Child income	How often? Weekly	Bi-Weekly	2x Month	Monthly	Annual
$	○	○	○	○	○

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report **total gross income** (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First & Last Name)	Earnings from Work	How often? Weekly	Bi-Weekly	2x Month	Monthly	Annual	Public Assistance/ Child Support/Alimony	How often? Weekly	Bi-Weekly	2x Month	Monthly	Annual	Pensions/Retirement/ All Other Income	How often? Weekly	Bi-Weekly	2x Month	Monthly	Annual
	$	○	○	○	○	○	$	○	○	○	○	○	$	○	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	○	$	○	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	○	$	○	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	○	$	○	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	○	$	○	○	○	○	○

Total Household Members (Children and Adults – Step 1 & Step 3) ____

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member X X X X X ____

Check if no SSN ☐

STEP 4 Contact Information and Adult Signature.

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Street Address (if available) | Apt # | City | State | Zip | Daytime Phone and Email (optional)

Printed name of adult signing the form | Signature of adult | Today's date

2021-22 Application for Free and Reduced-price School Meals or Free Milk

Sources of Income for Children		Sources of Income for Adults		
Sources of Child Income	**Examples**	**Earnings from Work**	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All Other Income**
Earnings from work	A child has a regular or part-time job where they earn a salary or wages	• Gross income for salary, wages, cash -- bonuses • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (*do NOT include combat pay, FSSA or privatized housing allowances*) • Allowances for off-base housing, food and clothing	• Unemployment benefits • Worker's compensation • Supplemental Security Income (SSI) • Cash assistance from state or local government • Alimony payments • Child support payments • Veteran's benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private pensions or disability • Regular Income from trusts or estates • Annuities • Investment income • Earned Interest • Rental income • Regular cash payments from outside household
Social Security • Disability Payments • Survivor's Benefits	A child is blind or disabled and receives Social Security benefits A parent is disabled, retired, or deceased, and their child receives social security benefits			
Income from persons **outside** the household	A friend or extended family member **regularly** gives a child spending money			
Income from any other source	A child receives income from a private pension fund, annuity, or trust			

OPTIONAL Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced-price meals.

Ethnicity (check one): ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Race (check one or more): ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White

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 last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child 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 lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

fax: (202) 690-7442; or

email: program.intake@usda.gov.

This institution is an equal opportunity provider.

School Use Only Do Not Write Below This Line

The Determining Official (DO) for the school/district MUST complete this section. ***(Only convert to annual income if there are different frequencies of income listed in Step 3.)***

Annual Income Conversion: Weekly X 52 ◆ Every 2 weeks X 26 ◆ Twice a Month X 24 ◆ Monthly X 12

Directly Certified (DC) **based on the State DC List** as eligible for: ❑ SNAP ❑ TFA ❑ OT ❑ **FM** (Free Medicaid) ❑ **RM** (Reduced Medicaid). Date Certified on DC List: _____

❑ SNAP/TFA Household providing proof (must be confirmed by DO) of a handwritten case number ❑ Foster Child ❑ Head Start ❑ **Confirmed** Homeless or Runaway

❑ Income Household: Total household income: _____ per _____ Household Size: _____ ***ERROR PRONE?*** ❑ YES ❑ NO

Application approved for: ❑ Free Meals ❑ Reduced-price Meals ❑ Application Denied

Date Notice Sent: _____ Signature of DO: _____ Date: _____

DOING THE MOST GOOD

Consent to Publication

Minors

A form should be completed for each individual minor.

Name of Minor (First Last) _____ Birth Date (Month Day Year) _____ / _____ / _____

I certify that I am the parent/legal guardian of _____. I hereby irrevocably grant to The Salvation Army, its successors and assigns, its agents and those by whom it is commissioned, the absolute, unrestricted and unlimited license, right, permission, and consent to use and reuse, disseminate, copyright, print, reproduce, publish and republish, for any and all trade purposes or commercial or other advertising or public purposes, and in any and all advertising, publicity, display, publication or media, internet sites including social media sites, and any other multimedia or electronic medium existing now or in the future, Minor's name, signature and likeness, and any portraits, pictures, photographic prints or other representations of Minor, or in which Minor may appear, or any reproductions or sketches thereof or parts thereof, photographic or otherwise, with such additions, deletions, alterations or changes therein as you in your discretion may make, either separately or together with Minor's name or a fictitious name or the name of another person, with or without any statements or testimonials made by Minor, or authorized by Minor which you may, in your discretion, prepare for use in connection therewith. I warrant to The Salvation Army that I have not limited or restricted the use of Minor's name or photograph to the use of any organization or person.

I hereby grant unrestricted use of audio tracks, videos, or text, including in an electronic medium existing now or in the future, by The Salvation Army for such purposes as The Salvation Army may deem appropriate.

I hereby release and discharge The Salvation Army, its successors, assigns and agents from any and all claims and demands arising out of or in connection with the use of any of the foregoing, including any claims for defamation, invasion of privacy or violation of any statutory right.

There is no time limit on the validity of this waiver nor is there any geographic limitation on where these materials may be distributed. This waiver applies to all Salvation Army locations and events.

Witness by my hand as noted and sealed this day.

Address Line I _____

Address Line II _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

❑ (Please Check) I, hereby certify that I am the (parent)/(legal guardian) of the minor child or dependent named above and have executed this release on (his)/(her) behalf.

Parent/Guardian Print Name _____ Parent/Guardian Signature _____

Witness to Execution of Release // Witness Signee is not required to be a Salvation Army representative

Name (First Last) _____ Signature _____

Address Line I _____

Address Line II _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

Date Consent to Publication is completed _____ / _____ / _____

DOING THE MOST GOOD

CONSENT TO PUBLICATION

MENORES DE EDAD

Se debe completar un formulario para cada menor de edad.

Nombre completo del menor de edad _____ Fecha de nacimiento _____ / _____ / _____
(Nombre Apellido) (Mes/Dia/Año)

Certifico que soy el (padre) / (tutor legal) del menor o dependiente _____. Por la presente, les concedo irrevocablemente al Ejército de Salvación, a sus sucesores y cesionarios, a sus representantes y a aquellos por él designados, la licencia, el derecho, el permiso y el consentimiento absoluto, ilimitado y sin restricciones, para usar y reusar, difundir, registrar como propiedad literaria, imprimir, reproducir, publicar y reeditar, para cualquier fin comercial o mercantil o con otros fines publicitarios o públicos, y en cualquier propaganda, publicidad, exhibición, publicación o medios de comunicación, sitios de internet incluidas las redes sociales, y en cualquier otro medio electrónico que exista ahora o en el futuro, el nombre, firma y semejanza del menor de edad, y en cualquier retrato, imágenes, impresiones fotográficas u otras representaciones del menor de edad, o en las cuales pueda aparecer el menor de edad, o en cualquier reproducción o bosquejo del mismo o de un derivado fotográfico o de otra manera, con tales incorporaciones, supresiones, alteraciones o cambios en ello en los que ustedes, a su discreción, puedan hacer, ya sea por separado o en conjunto, con el nombre del menor de edad o con un nombre ficticio, o con el nombre de otra persona, con o sin declaraciones o testimonios hechos por el menor de edad, o autorizados por el menor, en los cuales ustedes pueden, a su discreción, preparar para usar en conexión con ello. Le garantizo al Ejército de Salvación que no he limitado ni restringido el uso del nombre o fotografía del menor de edad para el uso de cualquier organización o persona.

Por la presente le otorgo el uso ilimitado de las pistas de sonido, videos o textos, que se incluyan en un medio electrónico que exista ahora o en el futuro, al Ejército de Salvación para dichos propósitos como el Ejército de Salvación considere apropiado.

Por este medio libero y exonero al Ejército de Salvación, a sus sucesores y cesionarios y a sus representantes de cualquiera y todos los reclamos y demandas que surjan de o en conexión con el uso de cualquiera de lo antes mencionado, incluyendo cualquier reclamo por difamación, invasión a la privacidad o violación de cualquier otro derecho legal.

No existe un plazo para la validez de esta renuncia de derechos ni existe una limitación geográfica en donde se puedan distribuir estos materiales. Esta renuncia de derechos es aplicable a todas las ubicaciones y a todos los eventos del Ejército de Salvación.

Doy fe con mi firma y sello en este día.

Domicilio principal _____

Otro domicilio _____

Ciudad _____ Estado _____ Código postal _____

Teléfono _____ Correo electrónico _____

❑ (Por favor, marque aquí) Por la presente certifico que soy el (padre) / (tutor legal) del menor o dependiente antes mencionado, y he realizado esta autorización en su nombre.

Nombre completo del padre/Tutor legal _____ Firma del padre/Tutor legal _____

Testigo para la realización de la autorización // No es necesario que el testigo de la firma sea un representante del Ejército de Salvación

Nombre completo _____ Firma _____
(Nombre Apellido)

Domicilio principal _____

Otro domicilio _____

Ciudad _____ Estado _____ Código postal _____

Teléfono _____ Correo electrónico _____

Fecha en que se completa el consentimiento para la publicación _____ / _____ / _____

❑1 ❑2 ❑3 ❑4 ❑5 ❑6 *Camp Use Only*

Corps/Service Unit:

Last Name, First Name:

CAMP CONNRI
Est. 1979

Health History and Examination Form

american CAMP association ACCREDITED

PARTICIPANT INFORMATION

Name: _____

Birthdate: _____ Age: _____ Gender: Male ❑ Female ❑

Parent/Guardian Name(s): _____ Home Phone: _____

Address: _____ Work Phone: _____

City/State/Zip: _____ Cell Phone: _____

EMERGENCY CONTACTS (other than Parent/Guardian)

Name/Relationship: _____ Home Phone: _____

Address: _____ Work Phone: _____

City/State/Zip: _____ Cell Phone: _____

Name/Relationship: _____ Home Phone: _____

Address: _____ Work Phone: _____

City/State/Zip: _____ Cell Phone: _____

INSURANCE INFORMATION (Attach copy of Insurance Card)

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

If yes, indicate carrier or plan name: _____

ID#: _____ Group #: _____ Medicaid #: _____

Subscriber's Name: _____

* Please Note: If you do not have medical insurance, you will be billed for medical services provided.

FOR CAMP USE ONLY

SCREENING RECORD Screened by _____

Date(s) Screened: _____ Time(s): _____

Medications Received: _____

Observational notes: _____

GENERAL HEALTH QUESTIONS

HEALTH HISTORY (check, giving approximate dates)

Allergies:

Foods ☐ _____ Medications ☐ _____ Other ☐ _____

Insect Stings ☐ _____ Penicillin ☐ _____ _____

Illnesses:

Chicken Pox ☐ _____ Hay Fever/Seasonal ☐ _____ Hearing Problems ☐ _____

Asthma ☐ _____ Diabetes ☐ _____ Vision Problems ☐ _____

Ear Infections ☐ _____ Seizures ☐ _____ Behavior Problems ☐ _____

Hospitalizations or serious injuries (give dates): _____

Chronic or recurring illnesses: _____

Special Accommodations at school: _____

PARENTAL PERMISSION TO PROVIDE NECESSARY TREATMENT AND/OR EMERGENCY CARE

- ✓ I affirm that this health history is correct, and that my child has permission to engage in all camp activities, except as noted by his/her physician.

Permission To Treat:

- ✓ I hereby give permission for camp medical staff to administer first aid and medication to my child as delineated in the camp's standing orders.
- ✓ I hereby give permission for the medical staff selected by the camp director to order x-rays, routine tests, treatment, to hospitalize, to release any records necessary, to secure proper treatment, to order injections and/or anesthesia and/or surgery for my child as described, and to provide related transportation for my child. *It is the responsibility of the parent/guardian to provide transportation for their child to their doctor or home if deemed necessary by the camp nurse.*

Over-The-Counter Medications:

- ✓ I hereby give permission for the following medications to be administered to my child if deemed necessary *when the nurse is available*. Dosages will be administered according to directions printed on the original containers unless a physician directs otherwise. Please cross off any medications that you ***do not*** want administered to your child.

To Treat	Medications Used*	To Treat	Medications Used*
Antibiotic treatment	**Bacitracin, triple antibiotic cream, Neosporin**	Headache	**Acetaminophen (Tylenol)**
Colds	**Sudafed**	Insect bite	**Medicaine insect swab**
Constipation	**Metamucil**	Menstrual cramps	**ibuprofen (Advil)**
Cough	**Robitussin DM syrup or drops**	Poison Ivy	**Caladryl, Calagel, or Cortaid**
Diarrhea	**Imodium AD**	Rash	**Hydrocortisone cream**
Disinfection	**isopropyl alcohol**	Seasonal allergies	**Benadryl**
Emergency allergy	**EpiPen**	Sore throat	**Chloraseptic spray / lozenges**
Eye Wash	**Saline solution**	Toothache	**Anbesol**
		Upset stomach	**Pepto Bismol, Mylanta**

***Camp CONNRI reserves the right to substitute any of these medicines for the generic equivalent.**

THIS MUST BE SIGNED BY ALL PERSONS IN ALL CIRCUMSTANCES!!

SIGNATURE: _____ **DATE:** _____

(Parent/Guardian must sign if under child is under 18)

MEDICAL EXAMINATION

To be filled out by your child's physician.

This examination should be performed **within 12 MONTHS** of the first day of the camp session the child is attending. An examination for some other purpose within this period is acceptable and can be attached to this form. The examination is for determining fitness to engage in strenuous outdoor activity.

IMMUNIZATION HISTORY (Required by State Law): Include all dates of basic immunizations services provided.

DPT	1st	2nd	3rd	4th	5th
MMR	1st	2nd	TETANUS BOOSTER	Date	
VARICELLA	Date	HEPATITIS B	1st	2nd	3rd
TUBERCULIN TEST	Date	Type	Results	Other	

Code: ✓ = Satisfactory × = Not Satisfactory ○ = Not Examined

Height_____Weight_____(lbs.)__Blood Pressure _____ Eyes_____Head_____Ears _____

Nose_____Throat_____Teeth_____Heart _____ Lungs_____Abdomen _____ Hernia_____

Extremities_____ Posture (Spine)_____Skin _____

Comments or explanations _____

Allergy (food, drug, other - specify type and kind) _____

General Appraisal _____

Applicant is under the care of a physician for the following condition(s) _____

Recommendations or restrictions at camp

- ❑ Special Diet _____
- ❑ Swimming _____
- ❑ Strenuous Activity _____

Comments on recommendations/restrictions _____

Please check one: This camper **is** ☐ **is not** ☐ fit to attend Camp CONNRI.

Please note: CAMP CONNRI IS NOT EQUIPPED TO SERVE CAMPERS WITH SEVERE MEDICAL CONDITIONS OR BEHAVIORAL DISORDERS. The Camp recommends that children remain on any medications prescribed for them during the school year. An adequate supply of all medication must be sent to camp in the original containers.

SIGNATURE OF LICENSED MEDICAL PERSONNEL (*MD, Physician's Assistant, or Nurse Practitioner*)

Signature_____ Title_____

Print Name_____ Phone (_____)_____

Address_____

Date of Examination _____

PLEASE CHECK ONE:

- ❑ ***This person takes NO medications on a routine basis. (This will complete the application.)***
- ❑ ***This person takes medications as follows. (The application is incomplete. Please turn to the next page.)***

*AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS

To be filled out by your child's physician.

In Connecticut, licensed camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. Parents/Guardians requesting medication administration to their child from camp staff shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication will be destroyed if not picked up within one week following the camper's departure at the end of camp. **PLEASE make copies of this form if bringing additional medications to camp. We must have authorization to administer each medication.**

AUTHORIZED PRESCRIBER OR DENTIST'S ORDER (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child_____Date of Birth_____Today's Date _____

Known Food or Drug: Allergies ❑Yes ❑No Reactions to? ❑Yes ❑No Interactions with? ❑Yes ❑No

If "yes" to any of the above, please explain _____

Prescription Medication / Over-the-Counter Meds	**Prescription / OTC #1**	**Prescription / OTC #2**
Medication Name		
Dosage		
Method		
Time of Administration		
May Self-Administer Inhalants	❑Yes ❑No Initial _____	❑Yes ❑No Initial _____
Controlled Drug?	❑Yes ❑No	❑Yes ❑No
Specific Instructions for Medication Administration		
Relevant Side Effects of Medication		
Plan of Management for Side Effects		

Prescriber's Name_____Phone Number (____)_____

Prescriber's Address_____Town_____

PRESCRIBER'S SIGNATURE:_____

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION

I request that medication be administered to my child as described and directed above.

I authorize self-administration of inhalants approved by Prescriber ❑ Yes ❑No Initial _____

Name of Camp: Camp CONNRI Today's Date _____

Child's Name _____

Address_____Town, State, Zip _____

Name of Parent/Guardian Authorizing Administration of Medication _____

Relationship to child ❑Mother ❑Father ❑Guardian/Other explain _____

Address/Town/State/Zip_____Phone Number _____

Signature of Parent/Guardian Authorizing Administration of Medication

_____

CAMP CONNRI
Est. 1979

Individual Plan of Care for a Camper With Special Health Care Needs or Disabilities

Camper's Name: _____ Date of Birth: _____/_____/_____

The purpose of this form is for the parent to provide an appropriate plan of care for their camper in a medical emergency. An individual Plan of Care is required when a camper has a special health care need such as asthma, allergies, or a disability. It is necessary that special care be taken or provided while the camper is at youth camp.

Explain Special Health Care Needs or Disability:

Explanation of the Plan of Care:

Other Relevant Information: (e.g. precautions to be taken to prevent a medical or other emergency)

Parent(s) Signature: Date Signed:

_____ _____/_____/_____

_____ _____/_____/_____

NOTE: Section 428-3(a) requires a child's health record to include information regarding disabilities or special health care needs such as allergies, special dietary needs, dental problems, hearing or visual impairments, chronic illness, developmental variations or history of contagious disease, and an individual plan of care for the child with special health care needs or disabilities. The plan shall be developed with the child's parent(s) and health care provider and updated as necessary. Such plan of care shall include appropriate care of the camper in the event of a medical or other emergency and shall be signed by the parent(s) and staff responsible for the care of the camper.

Please use the reverse side of this form for signature(s) of all staff responsible for the care of this child.