

44 Sherman Street • Springfield, MA 01109 • 413.739.5626 • F: 413.732.5457 • www.StudyHome.org

## CAMP CASA APPLICATION

### Demographic Information

Please Note: The confidential information requested throughout this form is used for grant data collection purposes only.

This information is compiled and processed without any personal, identifying information.

The Children's Study Home respects your right to privacy.

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**Applications are due back to the Children's Study Home by June 15, 2018**

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### HOUSEHOLD DEMOGRAPHICS

Primary Language/s Spoken in the Household: \_\_\_\_\_ Age (of camper): \_\_\_\_\_

Number of Family Members Living in the Household: \_\_\_\_\_ Gender (of camper): \_\_\_\_\_

Household Structure:

- Single parent household     Two-parent household     Multi-generational household

Race: *Please check all that apply:*

- White     Black/African American     Asian     American Indian/Alaskan Native  
 Native Hawaiian/Other Pacific Islander     Other

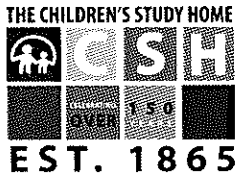
Ethnicity:

- Hispanic or Latino     Not Hispanic or Latino
- 

### HOUSEHOLD INCOME

Annual Family Income:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Under \$18,400    | <input type="checkbox"/> \$35,001-\$36,730 | <input type="checkbox"/> \$52,651-\$54,250 |
| <input type="checkbox"/> \$18,400-\$21,000 | <input type="checkbox"/> \$36,731-\$39,400 | <input type="checkbox"/> \$54,251-\$57,750 |
| <input type="checkbox"/> \$21,001-\$23,650 | <input type="checkbox"/> \$39,401-\$40,890 | <input type="checkbox"/> \$57,751-\$65,800 |
| <input type="checkbox"/> \$23,651-\$26,250 | <input type="checkbox"/> \$40,891-\$43,750 | <input type="checkbox"/> \$65,801-\$71,100 |
| <input type="checkbox"/> \$26,251-\$28,410 | <input type="checkbox"/> \$43,751-\$46,100 | <input type="checkbox"/> \$71,101-\$76,350 |
| <input type="checkbox"/> \$28,411-\$30,650 | <input type="checkbox"/> \$46,101-\$47,250 | <input type="checkbox"/> \$76,351-\$81,600 |
| <input type="checkbox"/> \$30,651-\$32,570 | <input type="checkbox"/> \$47,251-\$50,750 | <input type="checkbox"/> \$81,601-\$86,900 |
| <input type="checkbox"/> \$32,571-\$35,000 | <input type="checkbox"/> \$50,751-\$52,650 | <input type="checkbox"/> Over \$86,90      |



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## CAMP CASA APPLICATION

### Camper Fact Sheet

Please Note: The confidential information requested throughout this application is used for camp administration purposes only.

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#### CAMPER INFORMATION

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Phone: \_\_\_\_\_ School Recently Attended: \_\_\_\_\_ Grade Recently Completed: \_\_\_\_\_

#### GUARDIAN INFORMATION

##### GUARDIAN 1

Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Primary Language: \_\_\_\_\_ Place of Employment: \_\_\_\_\_ Ph: \_\_\_\_\_

##### GUARDIAN 2

Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Primary Language: \_\_\_\_\_ Place of Employment: \_\_\_\_\_ Ph: \_\_\_\_\_

#### EMERGENCY CONTACT INFORMATION\*

*\*Emergency contact must be different from guardian listed above*

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Primary Language: \_\_\_\_\_ Place of Employment: \_\_\_\_\_ Ph: \_\_\_\_\_



**CAMP CASA APPLICATION**

*Health Information*

**CAMPER INFORMATION**

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_ Last Dental Exam: \_\_\_\_\_

**HEALTH INFORMATION**

*Please check all health conditions that apply:*

- None
- Heart Condition
- Other (Please describe):  
\_\_\_\_\_
- Diabetes
- Asthma
- Seizure Disorder
- Migraines

**HEARING:**     None                     Right Ear             Left Ear             Hearing Aides  
**VISION:**         None                     Wears Glasses     Wears Contacts  
**ALLERGIES:**    None                     Yes (Please Describe)

Does your Child have an Epi-pen for any allergies?     Yes             No

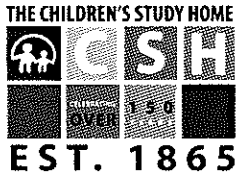
**MEDICATION INFORMATION:**

Will your child have medications to be taken at camp?     Yes             No

Please list any medications to be taken at camp:  
\_\_\_\_\_

Please list all medications that this child takes:  
\_\_\_\_\_

***If medication is to be taken at camp, you must speak with the Camp Director. Additional consents must be signed by parent/guardian. No medication can be given at camp unless this procedure is followed.***



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**CAMP CASA APPLICATION**

*Health Information (Continued)*

**INSURANCE INFORMATION**

Health Insurance Provider: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Does your child have dental insurance?     Yes     No

Dental Provider: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**PROVIDER INFORMATION**

Health Care Provider (ex., Doctor): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Dental Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I understand that The Children's Study Home will share information relevant to this child's health condition with appropriate camp personnel when needed to meet their health care needs.

In case of a medical emergency, I understand that The Children's Study Home will attempt to contact the emergency contacts I have provided. If deemed necessary and appropriate staff will arrange for transport to the nearest hospital.

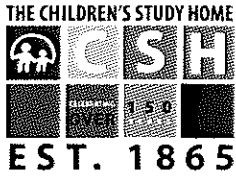
I give permission for The Children's Study Home staff to give first aid for minor injuries, including bruises, cuts, and burns.

Yes     No

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

Relationship to Child: \_\_\_\_\_



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## CAMP CASA APPLICATION

### *Family Expectations*

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A \$30 deposit upon registration is required.

This \$30 will be fully refunded at the end of camp as long as the following conditions are met:

- Campers attend 100% of camp days. If a camper cannot attend a day, the family will be responsible for contacting Camp CASA to report their child's absence.
- Drop off and pick up on time. Drop off time is from 8:30 a.m. – 8:45 a.m. Pick up is at 2:30 pm. Families are expected to either pick up or drop off every day, meaning that ***a camper is only allowed to walk one way to camp every day unattended.***
- Camp Casa extended day hours are 2:30pm to 5:30pm. ***\$15.00 per camper per day deposit is required.***
- As long as these rules are followed, families will be fully refunded their \$30 deposit. If these rules are not followed, Camp CASA reserves the right to not return the deposit.

\_\_\_\_\_ I have read and understand the following rules and conditions regarding Camp CASA and the return of my deposit.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

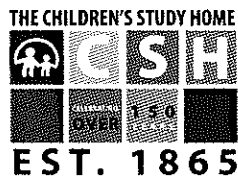
Relationship to Child: \_\_\_\_\_

Camp CASA is excited to be able to provide activities that will be fun and exciting for campers! In order to do this, Camp CASA has been raising money to support this program. If you wish your deposit to be donated to support camp activities, please sign below. Thank you for your support!

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

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## CAMPER PICK-UP AUTHORIZATION FORM

The Following people are authorized to pick up \_\_\_\_\_ from Camp CASA.  
(Camper's name)

(Please note that a valid ID must be shown to the Counselor in order for your camper to be picked up.)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Relationship to Camper)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Relationship to Camper)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Relationship to Camper)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Relationship to Camper)

\_\_\_\_\_  
(Print Your Name)

\_\_\_\_\_  
(Relationship to Camper)

\_\_\_\_\_  
(Signature)

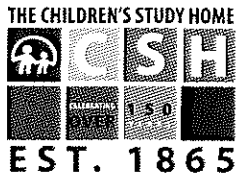
## WALKING CAMPER AUTHORIZATION

I give permission for my Camper to walk home from Camp CASA. Please note that if the weather is too severe for walking, then it will be expected that your Camper will be picked up from Camp at 2:30 pm. (Camp CASA and The Children's Study Home assume no responsibility for your Camper once they leave Camp property).

\_\_\_\_\_  
(Print Your Name)

\_\_\_\_\_  
(Relationship to Camper)

\_\_\_\_\_  
(Signature)



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## FIELD TRIP PERMISSION FORM

I authorize \_\_\_\_\_ to participate in any off-site field trips sponsored by  
(Camper's name)  
Camp CASA. (Some of the destinations we are considering, but are not limited to are: Springfield Library,  
Springfield Museums, Basketball Hall of Fame, and swimming at the Rebecca Johnson School.

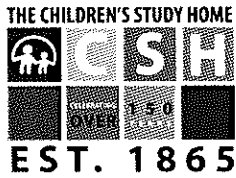
I understand that the necessary arrangements, plans, and precautions will be taken for the care and supervision of the camper during these trips.

\_\_\_\_\_  
(Print Your Name)

\_\_\_\_\_  
(Relationship to Camper)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)



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## PHOTO/VIDEOGRAPHY RELEASE FORM

I grant permission to The Children's Study Home, its representatives, and its employees, the right to take and use visual and/or audio images of me. Visual/audio images are any type of recording, including photographs, digital images, drawings, renderings, voices, sounds, video recordings, audio clips, or accompanying written descriptions.

I authorize The Children's Study Home to copyright use, and publish the same in print and/or electronically for such purposes as publicity and advertising.

I have read and understand the above:

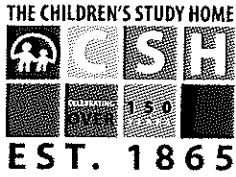
\_\_\_\_\_  
(Signature) (Date)

\_\_\_\_\_  
(Print Your Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
Signature of Parent/Guardian (if under age 18)





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## EXTENDED DAY FORM

Camp Casa would like to offer extended day, it will be held each day of camp from 2:30-5:30pm at a cost of \$15.00 per day.

*In order to offer this we will need to have at least 3 campers each day.*

I am interested in Extended Day

I am not interested in Extended Day

If you are interested I will need the following completed and returned.

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Best time to be reached:

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# CERTIFICATE OF IMMUNIZATION

Name: \_\_\_\_\_

Date of Birth:     /     /

Sex:   M   F

Please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date	Vaccine Type	Vaccine		Date	Vaccine Type
<b>Hepatitis B</b> (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1			<b>Rotavirus</b> (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		
	2				2		
	3				3		
	4						
<b>Diphtheria, Tetanus, Pertussis</b> (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1			<b>Measles, Mumps, Rubella</b> (e.g., MMR, MMRV)	1		
	2				2		
	3			<b>Varicella</b> (e.g., Var, MMRV)	1		
	4				2		
	5			<b>Meningococcal Conjugate (MCV4), Hib-MenCY or Polysaccharide (MPSV4)</b>	1		
	6				2		
	7						
<b>Haemophilus influenzae type b</b> (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1			<b>Seasonal Influenza Inactivated</b> IIV3, IIV4, ccIIV3-IM, IIV3-ID, IIV3-HD	1		
	2			RIV3-IM	2		
	3			<b>Live Attenuated LAIV, LAIV4</b>	3		
	4				4		
<b>Polio</b> (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1			<b>2009 H1N1 Influenza</b> Inactivated or Live	1		
	2				2		
	3			<b>Pneumococcal Polysaccharide (PPSV23)</b>	1		
	4				2		
	5			<b>Hepatitis A</b> (e.g., HepA, HepA-HepB)	1		
<b>Pneumococcal Conjugate (PCV7, PCV13)</b>	1				2		
	2			<b>Human Papillomavirus (HPV4, HPV2)</b>	1		
	3				2		
	4			<b>Other:</b>	3		

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

\* Must also check Chickenpox History box.

Chickenpox History
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: <ul style="list-style-type: none"> <li>• physician interpretation of parent/guardian description of chickenpox</li> <li>• physical diagnosis of chickenpox, or</li> <li>• serologic proof of immunity</li> </ul>

*I certify that this immunization information was transferred from the above-named individual's medical records.*

Doctor or nurse's name (please print): \_\_\_\_\_

Date:     /     /

Signature: \_\_\_\_\_

Facility name: \_\_\_\_\_



## AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER

(To be completed by parent/guardian)

Name of Camper: \_\_\_\_\_ Age: \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_  
Food/Drug Allergies: \_\_\_\_\_ Home Telephone: \_\_\_\_\_  
Diagnosis (at parents discretion): \_\_\_\_\_ Business Telephone: \_\_\_\_\_  
Emergency Telephone: \_\_\_\_\_  
Name of Licensed Prescriber: \_\_\_\_\_ Business Telephone: \_\_\_\_\_  
Emergency Telephone: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dose given at camp: \_\_\_\_\_ Route of Administration: \_\_\_\_\_  
Frequency: \_\_\_\_\_ Date Ordered: \_\_\_\_\_ Duration of Order: \_\_\_\_\_ Quantity Received: \_\_\_\_\_  
Expiration date of Medications Received: \_\_\_\_\_ Special Storage Requirements: \_\_\_\_\_

Specific Directions (e.g., on empty stomach/with water): \_\_\_\_\_  
Specific Precautions: \_\_\_\_\_  
Possible Side Effects/Adverse Reactions: \_\_\_\_\_  
Other medications (at parents' discretion): \_\_\_\_\_  
Location where medication administration will occur: \_\_\_\_\_

(Over)

**Authorization to Administer Medication to a Camper (2)**

I hereby authorize \_\_\_\_\_ to administer, to my child, \_\_\_\_\_ the medication(s) listed above, in accordance with 105 CMR 430.160.

(NAME OF CAMP)

(NAME OF CHILD)

**105 CMR 430.160(A)**

*Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.*

**105 CMR 430.160(C)**

*Medication shall only be administered by the health supervisor\* or by a licensed health care professional authorized to administer prescription medications. The health care consultant shall acknowledge in writing the list of medications administered at the camp. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.*

**105 CMR 430.160(D)**

*When no longer needed, medications shall be returned to a parent of guardian whenever possible. If the medication cannot be returned, it shall be destroyed.*

\*Health Supervisor – A person who is at least 18 years of age, specially trained and certified in at least current American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_