THE CHILDREN'S STUDY HOME
EST. 1865

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.

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

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:

☐ Under $18,400
☐ $18,400-$21,000
☐ $21,001-$23,650
☐ $23,651-$26,250
☐ $26,251-$28,410
☐ $28,411-$30,650
☐ $30,651-$32,570
☐ $32,571-$35,000
☐ $35,001-$36,730
☐ $36,731-$39,400
☐ $39,401-$40,890
☐ $40,891-$43,750
☐ $43,751-$46,100
☐ $46,101-$47,250
☐ $47,251-$50,750
☐ $50,751-$52,650
☐ $52,651-$54,250
☐ $54,251-$57,750
☐ $57,751-$65,800
☐ $65,801-$71,100
☐ $71,101-$76,350
☐ $76,351-$81,600
☐ $81,601-$86,900
☐ 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.

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

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: _____

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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 ☐ Diabetes ☐ Seizure Disorder

☐ Heart Condition ☐ Asthma ☐ Migraines

☐ Other (Please describe):

_____

_____

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

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:

_____

_____

CERTIFICATE OF IMMUNIZATION

Name: **Date of Birth:** / / **Sex:** M F

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

Vaccine		Date	Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1		
	2		
	3		
	4		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1		
	2		
	3		
	4		
	5		
	6		
	7		
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1		
	2		
	3		
	4		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1		
	2		
	3		
	4		
	5		
Pneumococcal Conjugate (PCV7, PCV13)	1		
	2		
	3		
	4		

Vaccine		Date	Vaccine Type
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		
	2		
	3		
Measles, Mumps, Rubella (e.g., MMR, MMRV)	1		
	2		
Varicella (e.g., Var, MMRV)	1		
	2		
Meningococcal Conjugate (MCV4), Hib-MenCY or Polysaccharide (MPSV4)	1		
	2		
Seasonal Influenza Inactivated IIV3, IIV4, ccIIV3-IM, IIV3-ID, IIV3-HD RIV3-IM Live Attenuated LAIV, LAIV4	1		
	2		
	3		
	4		
2009 H1N1 Influenza Inactivated or Live	1		
	2		
Pneumococcal Polysaccharide (PPSV23)	1		
	2		
Hepatitis A (e.g., HepA, HepA-HepB)	1		
	2		
Human Papillomavirus (HPV4, HPV2)	1		
	2		
	3		
Other:			

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

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

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: _____

Food/Drug Allergies: _____

Diagnosis (at parents discretion): _____

Parent/Guardian Name: _____

Home Telephone: _____

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)
(NAME OF CAMP) (NAME OF CHIILD)
listed above, in accordance with 105 CMR 430.160.

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: _____