Berks County Intermediate Unit
an educational service agency

CAMP CONNECT - 2018
CHILD/TEEN APPLICATION

Please check which date you would like your child to attend: ☐ June 25-28 ☐ August 6-9

Date of Application: _____

Camper's Name: _____
(Last) (First) (Middle)

Home Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: _____

School Grade: _____ School Attending: _____

Parent/Guardian's Name: _____

Day Phone: _____ Evening Phone: _____

Email Address: _____

How did you hear about Camp Connect? _____

Have you talked to your child about attending Camp Connect? □ Yes □ No

What, if any, concerns do you have about your child going to camp? _____

_____

Child's T-Shirt Size: Child _____ S _____ M _____ L

Adult _____ S _____ M _____ L _____ XL

FOR OFFICE USE ONLY

Application received: _____ Date

Assessment: _____ Date

Approved: _____ Date

Immunizations received: _____ Date

Not Approved: _____ Date

Camper's Name: _____

Please List Emergency Contact Information for Child Attending Camp:

Name: _____

Day Phone: _____ Cell Phone_____

Name: _____

Day Phone: _____ Cell Phone_____

Parent/Guardian Signature: _____ Date: _____

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CAMP CONNECT
BEREAVEMENT HISTORY

Camper's Name: _____
Name of the person(s) who died: _____
Age of person at time of death: _____
Relationship of your child to deceased: _____
Date and cause of death: _____
Was the death anticipated? □ Yes □ No
Did your child experience strong denial prior to the death? □ Yes □ No
Was your child present at the time of death? □ Yes □ No
Comments: _____
_____
Did your child see the deceased after the death? □ Yes □ No
Did your child attend the funeral/memorial service? □ Yes □ No
If yes, what were your child's reactions/comments to the service? _____
_____
Do you and your child talk about the deceased? □ Yes □ No
Did you and/or your family receive counseling? □ Yes □ No
What behavior(s) does your child exhibit that indicate your child is still grieving? _____
_____
Has your child said or done anything recently that concerns you? □ Yes □ No
If so, please describe: _____
_____
Does your child have difficulty adjusting to new situations such as a day long camp?
□ Yes □ No
If so, how have you handled this? _____
_____
Has your child experienced any other deaths? □ Yes □ No
Comments: _____
_____
Have there been any other changes/stressors in your child's life (i.e. divorce, relocation, illness)?
□ Yes □ No
Comments: _____
_____

CAMP CONNECT
CAMPER INFORMATION

Camper's Name: _____

Has your child ever:

Attended day or overnight camp?	□ Yes	□ No

Does your child enjoy:

Music?	□ Yes	□ No
Outdoor activities?	□ Yes	□ No
Arts & Crafts?	□ Yes	□ No
Creative writing?	□ Yes	□ No
Sports/physical activity?	□ Yes	□ No
Reading?	□ Yes	□ No

Please list other activities your child enjoys doing: _____

_____

_____

Is there anything we should know to better accommodate your child? _____

_____

_____

Parent/Guardian Signature: _____ Date: _____

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CAMP CONNECT
CAMPER MEDICATION INFORMATION

Camper's Name: _____

Does your child have any of the following:			If yes, please explain:
Physical limitations	□ Yes	□ No	_____
Hearing impairment	□ Yes	□ No	_____
Ear infections	□ Yes	□ No	_____
Nose bleeds	□ Yes	□ No	_____
Mental Health Diagnosis	□ Yes	□ No	_____
Bed wetting	□ Yes	□ No	_____
Diabetes	□ Yes	□ No	_____
Eating disorder	□ Yes	□ No	_____
Dietary restrictions	□ Yes	□ No	_____
Constipation/diarrhea	□ Yes	□ No	_____
Asthma	□ Yes	□ No	_____
Breathing problems	□ Yes	□ No	_____
Epilepsy/seizures	□ Yes	□ No	_____
Sickle Cell Anemia	□ Yes	□ No	_____
Wears contact lenses/glasses	□ Yes	□ No	_____
Allergies	□ Yes	□ No	_____

Other illnesses or medical conditions which are significant to mention? □ Yes □ No
Please specify: _____

Will your child be taking medications at camp? □ Yes □ No
If yes, please specify below.

Medication/Dosage	**For what?**	**Time(s) to be given**
1.		
2.		
3.		
4.		
5.		
6.		

Camper's Name: _____

Method of administration (to be taken with water, milk, food, etc.): _____
_____

List any reasons for not giving medication at the prescribed time (vomiting, fever, drowsiness, convulsions): _____
_____

Immunizations: Please attached a copy of the most up to date immunization record

Parent/Guardian Signature: _____ Date: _____

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CAMP CONNECT
PERMISSION TO ADMINISTER MEDICATIONS

To be completed by parent or guardian.

Camper's Name: _____ Birth Date: _____

Camp Connect is staffed by a registered nurse. The nurse may not diagnose or prescribe medication or treatment.

In order to relieve your child's distress when ill, the Camp Health Professional needs your written permission to administer the following over-the-counter medications. Medications will be administered only when deemed necessary by camp health personnel and only at recommended weight/age dosages as listed on the product label.

Please place your **initials** next to whichever over-the-counter medications you are authorizing. If you do not authorize medications supplied by camp, please initial the space provided for "NO" and indication the substitute that you will send to camp for your child.

1. **For pain, fever, cramps, headache – INITIAL ONLY ONE.**
   _____ No preference. Camp has my permission to administer either Acetaminophen (Generic substitute for Tylenol) or Ibuprofen (Generic substitute for Advil).
   _____ Camp has my permission to administer only Acetaminophen (Generic substitute for Tylenol).
   _____ Camp has my permission to administer only Ibuprofen (Generic substitute for Advil).
   _____ NO, I will send _____

2. **For allergic reaction to insect bite/sting Benadryl or generic Diphenydramine**
   _____ YES, camp has my permission to administer _____ NO, I will send _____

3. **To relieve itching (poison ivy/insect bite/rash) anti-itch topical (Benadryl spray/Caladryl lotion)**
   _____ YES, camp has my permission to administer _____ NO, I will send _____

4. **To cleanse eyes/eyewash – Hypotears Saline Solution**
   _____ YES, camp has my permission to administer _____ NO, I will send _____

5. **To induce vomiting – Ipecac**
   _____ YES, camp has my permission to administer _____ NO, I will send _____

6. **To prevent ticks – insect repellent with a small percentage of DEET recommended for age group**
   _____ YES, camp has my permission to administer _____ NO, I will send _____

If you send an alternate over-the-counter remedy or prescription medication, it must be kept by the camp nurse. All medications sent from home must be in the **original pharmacy container**, and if prescription, **prescribed in the name of the child. ALL medications must be properly labeled with the child's name, and accompanied by instructions, signed by parent/guardian, indicating dosage, and time(s) to be administered.**

Camper's Name: _____

For bee/insect stings, our protocol is to remove the stinger when possible, apply ice at site of bite/sting, and observe child. Benadryl will be administered if deemed necessary by the nurse, or if there is a history of reaction as indicated below. For a severe reaction, an Epi-Pen will be given.

□ No history – has never been stung.

□ Stung and had an allergic reaction.

□ Stung but had no allergic reaction.

□ Check here if anyone in your child's immediate family has experienced a severe allergic reaction to bee/insect stings.

□ Epi-Pen being sent by parent/guardian.

□ If there is any additional information that the Camp Connect Staff should know concerning your child, please check this box and attach a separate sheet to this form.

Parent/Guardian Signature: _____ Date: _____

Adapted with permission by Pathways Center for Grief & Loss

CAMP CONNECT
PARENT/LEGAL GUARDIAN PERMISSION STATEMENT

Berks County Intermediate Unit considers the information you provide regarding your child to be confidential. It will only be made available, to the extent necessary, to appropriate camp staff, volunteers, and counselors who will be working with your child.

I understand and agree that if my child appears ill prior to attending camp, I will not send my child to camp.

To communicate the mission of Camp Connect, the Berks County Intermediate Unit may use quotations, stories, artwork, publicity, and other artistic expressions of the children and teens for brochures, newsletters, the web site, lectures or trainings. The last name and any details or identifying information about the child will not be spoken or printed. I understand and agree that the Berks County Intermediate Unit's Camp Connect may photograph my child and utilize photographs for presentations or publications for educational purposes.

Limitations/exclusions if applicable: _____
_____

Permission is granted for my child to participate in all camp activities (which are more fully described in camp materials) except as limited or excluded in the Health History Form. I am not aware of any other health reason(s) (other than those documented) that would preclude my child from participating in camp activities.

I confirm that all information provided is, to the best of my knowledge, accurate and complete.

I understand that, in the event of a medical emergency I will be immediately contacted. Berks County Intermediate Unit on-site medical staff (registered nurse, CPR certified staff and/or physician) will initiate immediate medical, and if necessary, life sustaining measures and will contact, if needed, emergency medical personnel for assistance.

I further understand that my preferred physician/medical facility will be contacted and utilized whenever possible. If I am unable to be reached and medical circumstances require immediate transport for care, this will be initiated and emergency medical personnel will provide for the immediate needs of my child and determine the transport location.

Preferred Physician Name: _____ Phone Number: _____
Medical Insurance: _____ Phone Number: _____
Policy Holder's Name: _____ Group Number: _____
Employer: _____

I hereby release and discharge Berks County Intermediate Unit, its employees or volunteers from any legal responsibility and/or liability for any personal injuries or illnesses, either physical or emotional; or injury to property, real or personal, whether that injury is due to negligence or any other fault, which may occur while my child is transported to and from and attends Camp Connect. I have read the information on Camp Connect. I have received Berks County Intermediate Unit's *Notice of Privacy Practices.* I understand the Camp Connect program provided by the Berks County Intermediate Unit, have had the opportunity to ask questions and have received acceptable and understandable answers. I choose to avail myself/my children of this service voluntarily and with full knowledge of its benefits and limitations.

_____
Child's Name (please print)

_____ _____
Parent/Guardian Signature Date

For June 25-28, 2018 camp, please return application by May 18, 2018.

For August 6-9, 2018 camp, please return application by June 15, 2018.

Applicants will be accepted on a first come, first serve basis.

Please mail completed application to:

Attn: Camp Connect
Berks County Intermediate Unit
1111 Commons Blvd
PO Box 16050
Reading, PA 19612

Or

email to:

campconnect@berksiu.org