



Amazing Grace Camper Program

WELCOME!

Welcome to the opportunity to participate in the Amazing Grace Program at Camp Burgess. Please complete all the forms in this packet. We ask for a lot of information and apologize that the same or similar information is asked in different places. **The person who has legal authority to grant permission for the child to attend camp must complete the forms.** This person must have either temporary or permanent residential custody of the child. Please use the checklist below to be certain you have not missed anything.

Once you have returned all the materials, we will review these forms and determine if Amazing Grace is appropriate for your child. We request you return these forms as soon as possible. We will do everything possible to include your child in this wonderful experience. Notification of acceptance into the Amazing Grace camp program will be mailed within two weeks of receipt of all forms.

CAMP DATES ARE SUNDAY AUGUST 18 to FRIDAY AUGUST 23, 2019

FORMS CHECKLIST

- ___ 2019 Application Form
- ___ 2019 Camper Information Forms (2 pages)
- ___ Risk Assessment Form
- ___ Consent for Contact Form
- ___ Photo and Transportation Release Form
- ___ Completed Medical Forms - This includes a Physician's Report/Immunization Record, as well as a Front/Back Copy of Insurance Card (4+ pages)

Please mail these forms back, using the enclosed pre-addressed, stamped envelope to:

**Amazing Grace of Cape Cod, Inc.
P.O. Box 636
Centerville, MA 2632**

You may contact Deer Sullivan, Program Director at 508-896-0017 or email amazinggracecapecod@gmail.com with any questions.

Happy Camping!



AMAZING GRACE OF CAPE COD 2019 APPLICATION FORM

Camper's Name _____

Date of Birth _____

Parent/Guardian Information

Last name _____ First Name _____

Relationship to Camper _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Mobile _____ Email _____

Preferred method of contact: (circle) home phone mobile text email messenger other _____

Emergency Contact

Name _____ Relationship to Camper _____

Phone _____ Mobile _____ T- _____

shirt size: Youth S M L XL Unisex Adult S M L XL

How did you hear about us? _____

I have legal custody of this child. _____ If

not a parent, in what court were you granted guardianship? Docket number, if known _____ Who

is authorized to pick up or transport the child? _____

I understand and agree to all of the above terms and conditions unless indicated.

Signature of Legal Guardian _____ **Date** _____



AMAZING GRACE OF CAPE COD 2019 CAMPER INFO FORM

Help us get to know your child, so that we can help ensure a positive camp experience.

Camper's Name _____

Prefers to be called _____ Age _____

School _____ Grade completed June 2019 _____

Names and Ages of siblings _____

Are there other family members (step parent, grandparents, cousins, aunts/uncles) or friends of the family that the child has regular contact with? Please include name(s) and relationship(s).

Name of Incarcerated Family member _____ Relationship to camper _____

Facility _____ Presently incarcerated? _____ Released? _____

Does the camper have contact with this person? _____ How frequently? _____

Please explain answers in the spaces below.

1. What is the camper's favorite activity at school?

2. What are the camper's special interests and/or talents? (e.g. music, sports, drama)

3. Is this the camper's first experience at camp? Away from home overnight? At an overnight camp?

(continued on back)

4. Does the camper take medication on a regular basis for school? Yes or No _____
What kind of medication?

(Since camp will be scheduled and is more like school than summer vacation, we would encourage you to provide this medication for camp week. See health form.)

5. Has the camper experienced significant life event(s) that continues to affect the camper's life?
(History of abuse, death of a loved one, family change, foster care, new sibling, other)

6. Please describe any emotional or behavioral difficulties of which we should be aware.

7. Please share ideas of how to help the camper if he/she becomes upset/homesick?

8. What else should we know about the camper to help ensure a positive camp experience?



Amazing Grace Risk Assessment

CamperName: _____

Parent/GuardianName: _____

Precautions will be made to prevent accidents and safety equipment will be required to be worn for some activities.

1 During the course of the Amazing Grace programs, campers will have the opportunity to participate in various activities that involve risks. For example: campers may participate in low and/or high ropes course activity, and rock climbing, with potential for slips and falls which could result in scratches, bruises, sprains, lacerations, fractures, or concussions. Campers may also participate in water activities, hikes, outdoor games, and various other physical activities that present a risk for injury.

2 I understand that sometimes campers will be transported by YMCA or other vehicles to activities off campus, especially to YWCA Camp Hayward by licensed drivers. I authorize my child to participate.

3 I acknowledge that my child's participation in activities while at camp entails known and unanticipated risks, which could result in physical or emotional injury. While particular rules, equipment, and personal discipline may reduce the risk, the possibility of serious injury does exist. I understand that such risks cannot be eliminated without jeopardizing the essential qualities of the activities.

4 On behalf of my minor child, and myself, I expressly agree and promise to accept and assume all of the risks existing in these activities. I recognize that my child's participation in these activities is purely voluntary, and I authorize his or her participation despite the risks.

5 I certify that I have adequate insurance to cover treatment of any injury suffered by my child while participating in camp activities, or else I agree to bear the costs of such injury myself.

6 By signing below, I hereby voluntarily release the South Shore YMCA–Camp Burgess and Hayward and Amazing Grace of Cape Cod, Inc., their respective agents, owners, officers, employees, volunteers, or other participants from any and all claims, demands or causes of action that are in anyway connected with my minor child's participation in camp activities.

By my signature, I agree to the terms above.

Parent/GuardianSignature Date



Amazing Grace of Cape Cod, Inc. Agreement to Allow Year-Round Contact with Campers

Camper Name _____

Parent/Guardian Name _____

Amazing Grace of Cape Cod Inc. believes that a child's camp experience can be strengthened by further supportive contact throughout the year.

I hereby give permission to Amazing Grace of Cape Cod, Inc., including any of its agents, to communicate with me and my child. This may include newsletters, birthday cards, holiday greetings and phone calls approved by the board of the program.

My child and I would like to be informed about participating in gatherings, mentoring opportunities or other activities encouraged by Amazing Grace of Cape Cod Inc.

I have read the foregoing fully, understand the contents, and give my consent.

Signature of Parent or Guardian _____ Date _____

Printed name of Parent or Guardian _____



Amazing Grace Camper Program 2019 Media Release Form 2019 Transportation Release Form

Camper Name: _____

Amazing Grace of Cape Cod, Inc. would like to have your permission to take photographs and videos of all participants while taking part in Amazing Grace's camp experience and other activities. I understand that they may be used to create or update Amazing Grace promotional materials such as brochures, posters, calendars, our website <http://www.amazinggracecapecod.org/> and for our closed Facebook page <https://www.facebook.com/groups/343702532453385>. I further understand that these materials may be used to recruit campers and volunteers as well as for fundraising.

We will not use the names or addresses of campers, their families, nor guardians.

I give permission to include my child's image in these materials and sites. _____

I do not give permission to include my child's image in these materials and sites _____

Signature of parent or guardian _____ Date _____

Printed name of parent or guardian _____

Amazing Grace of Cape Cod, Inc. and/or the South Shore YMCA-Camp Burgess may provide transportation for activities. The children will be briefed on safety procedures before the car, van, or bus departs. If transportation is provided, at least two chaperones will accompany the children.

I give permission for Amazing Grace of Cape Cod Inc. to provide transportation for activities.

Signature of parent or guardian _____ Date _____

Printed name of parent or guardian _____



CAMPER HEALTH FORM

South Shore YMCA
Camp Burgess & Hayward
75 Stowe Rd. • Sandwich • MA • 02563 the
Phone: 508-428-2571



- This health history is up-to-date and accurate as far as I know, and the person described herein has my permission to engage in all camp activities, except as noted on this form.

EMERGENCY AUTHORIZATION:

- I hereby authorize the medical personnel selected by the Camp Director to order x-rays, routine tests, and treatment for my child.
- In the event that I cannot be reached in an emergency, I also hereby permit the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to authorize injection and/or anesthesia and/or surgery for my child as named herein.
- I also give permission for routine medical care for my child by the Camp (including the administering by the camp medical personnel of any prescribed medication which my child brings to the Camp or which is prescribed while at the Camp).
- I also authorize the use of over the counter medications for my son/daughter when needed by the Camp.
- This form may be photocopied for use off Camp property.

Parent or Legal Guardian: _____ Date: _____
Signature mm dd yyyy

Pages 1, 2 & 3 to be filled out by Parent/ Legal Guardian
Page 4 to be filled out by a Licensed Physician

Please send in completed form by July 1st

Camper Name: _____ Male Female
First Middle Last

Birth Date: _____ Age while at Camp: _____ Session(s) attending Camp: 1 1a 1b 2 3 4 5
mm/dd/yyyy Please Circle

Camper Home Address: _____
Street Address City State Zip

Parent/Legal Guardian: _____ Relationship to Camper: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

*If you will be on vacation, please provide the best number to reach you at: _____

Second parent/guardian or other emergency contact:

Parent/ Legal Guardian: _____ Relationship to Camper: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Allergies:

No known allergies. This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe what the camper is allergic to and the reaction seen)

Diet & Nutrition:

This camper eats a regular diet This camper eats a regular vegetarian diet This camper has special food needs (Please describe below)

Medication:

This camper does not take meds This camper takes daily scheduled meds (fill out page 2) This camper takes meds only as needed

Medical Insurance Information: ****Our pediatricians office requires a front-back copy of your insurance card.****

This camper is covered by family medical/hospital insurance Yes No

Insurance Company: _____ Policy Number: _____

Camper Name:

Last

First

Session:

CAMPER HEALTH FORM

Medication:

This camper will not take any daily medication(s) while attending Camp.

This camper will take the following medication(s) while attending Camp.

Name of medication	Date started	Reason for taking it	When it is given	Amount/dose given	How it is given
			Breakfast Lunch Dinner Bedtime Other time:		
			Breakfast Lunch Dinner Bedtime Other time:		
			Breakfast Lunch Dinner Bedtime Other time:		
			Breakfast Lunch Dinner Bedtime Other time:		

All medications, including prescription, non-prescription and vitamins, must come in original containers, clearly labeled with the child's name, name of the medication and direction for use. Prescribed medications must have the pharmacy label containing Rx number, the name of the medication, the dosage, directions for administration, and the camper's name. A copy of the doctor's prescription or letter may be sent to clarify any discrepancies.

General Health History: Check "Yes" or "No" for each statement.

Has/does the camper:

1. Ever been hospitalized?	Yes	No	14. Have fainting or dizziness?	Yes	No
2. Ever had surgery?	Yes	No	15. Ever passed out/had chest pain during exercise?	Yes	No
3. Have recurrent/chronic illnesses?	Yes	No	16. Have mononucleosis ("mono") during the past 12 months?	Yes	No
4. Have a recent infectious disease?	Yes	No	17. If female, have problems with periods/menstruation?	Yes	No
5. Have a recent injury?	Yes	No	18. Have problems with falling asleep/sleepwalking?	Yes	No
6. Have asthma/wheezing/shortness of breath?	Yes	No	19. Have back/joint problems?	Yes	No
7. Have diabetes?	Yes	No	20. Have a history of bedwetting?	Yes	No
8. Have seizures?	Yes	No	21. Have problems with diarrhea/constipation?	Yes	No
9. Have headaches?	Yes	No	22. Have any skin problems?	Yes	No
10. Wear glasses, contacts, protective eyewear?	Yes	No	23. Traveled outside the country in the past 9 months?	Yes	No
11. Have chicken pox?	Yes	No	24. Have convulsions?	Yes	No
12. Have heart condition?	Yes	No	25. Have a head injury?	Yes	No
13. Have frequent ear infections?	Yes	No	26. Other _____	Yes	No

Please explain "Yes" answers in the space below, noting the question number. For travel outside the country, please name countries visited and dates of travel.

CAMPER HEALTH FORM

Camper Name: _____
Last Middle First
Birth Date: _____
mm dd yyyy

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the camper:

- | | | |
|---|-----|----|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? | Yes | No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder? | Yes | No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns? | Yes | No |
| 4. Experienced a significant life event that continues to affect the camper's life?
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) | Yes | No |
- Please explain "Yes" answers in the space below, noting the question number. We may contact you for additional information.***

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (____) _____
Name of dentist(s): _____ Phone: (____) _____
Name of orthodontist(s): _____ Phone: (____) _____

What Have We Forgotten to Ask? Please provide in the space below any additional information about the camper's health that you think is important or that may affect the camper's ability to fully participate in Camp. Attach additional information if needed.

CAMPER HEALTH FORM

A PHYSICAL EXAMINATION BY A LICENSED HEALTHCARE PROVIDER MUST BE DOCUMENTED ON THIS FORM. THE EXAMINATION MUST TAKE PLACE NO MORE THAN 12 MONTHS PRIOR TO THE CHILD'S ATTENDANCE.
AN OFFICIAL PRINTED REPORT OF THE EXAMINATION CAN BE SUBSTITUTED, BUT MUST GIVE ALL THE INFORMATION THIS FORM ASKS FOR. ALL INFORMATION ASKED FOR ON THIS FORM IS *REQUIRED BY LAW*.

IMMUNIZATION VERIFICATION — REQUIRED BY MASSACHUSETTS LAW

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month / Year
Diphtheria, Tetanus, Pertussis (DTaP) or (TdaP)						
Mumps, Measles, Rubella (MMR)						
Polio						
Hepatitis B						

I have examined the person named below:

Camper Name: _____ Examination Date: _____
mm dd yyyy

physician's initials

In my opinion the person named on this form IS healthy enough to participate fully in an active camp program.

physician's initials

In my opinion the person named on this form IS NOT healthy enough to participate fully in an active camp program.

The camper is under a physician's care for the following condition(s):

Current treatment - include current medication(s):

Does this camper have tuberculosis in a communicable form or symptoms thereof?	Yes	No
Does the camper have epilepsy?	Yes	No
Does the camper have diabetes?	Yes	No
If female, is her menstrual history normal?	Yes	No

Recommendations and/or restrictions for this individual while at Camp
(any treatment to be continued; any medication to be administered; any dietary restrictions; any allergies to foods, drugs, plants, insects, etc.):

Additional information:

Physician's Signature: _____ Printed Name: _____

Address: _____ Phone: _____ Date: _____
mm dd yyyy