Amazing Grace Camper Program

WELCOME!

Dear Parent or Guardian and Camper:

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 19 to FRIDAY AUGUST 24, 2018

FORMS CHECKLIST

____ 2018 Application Form
____ 2018 Camper Information Forms (2 pages)
____ Risk Assessment Form
____ Photo and Transportation Release Form
____ Consent for Contact 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 them back, using the enclosed pre-addressed and stamped envelope to:

Amazing Grace of Cape Cod, Inc.
P.O. Box 636
Centerville, MA 02632

Please contact Camp Director, Julie Lytle at 617-669-8411 or amazinggracecapecod@gmail.com with any questions.

Happy Camping!
Eileen Putman

AMAZING GRACE OF CAPE COD
2018 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: (pls 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? _____

_____

NAME TELEPHONE
RELATIONSHIP

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

Signature of Legal Guardian _____ Date _____

AMAZING GRACE OF CAPE COD
2018 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 2018 _____

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? _____ What kind?

_____

_____

_____

(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

Camper Name:_____

Parent/Guardian Name:_____

Precautions will 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 YMCA 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 any way connected with my minor child's participation in camp activities.

By my signature, I agree to the terms above.

_____ _____

Parent/Guardian Signature Date

Amazing Grace Camper Program
2018 Media Release Form
2018 Transportation Release Form

Camper Name: _____

Amazing Grace of Cape Cod, Inc. would like to have your permission to take photographs and videos of your child while participating 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

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

CAMPER
MEDICAL PAPERWORK

Dear parents and guardians,

In our efforts to become a more sustainable, greener Camp, beginning this year, we will only accept complete Camper medical packets, **as PDFs emailed to**:

rcnurse@ssymca.org

Please do not email portions of the packet separately. We will not accept faxed or mailed medical paperwork.

The complete packet consists of:

1. **The 4-page Camper Health Form**—please make sure to sign the Emergency Authorization at the top of the first page.

2. **A Physician's Report/Immunization Record**—this must be dated no more than 12 months prior to the child's attendance at Camp. You may substitute an official printed report for page four of the Health Form.

3. **A front-back copy of the camper's Medical Insurance Card.**

Please do not call or email to ask if we have received your paperwork. We will contact you if we are missing anything.

Lastly, please bring a back-up copy of the paperwork with you to check-in, in the event the nurses are missing anything.

These measures have been put into place in an effort to ensure the Health Centers are in possession of everything they require prior to the start of the session, and to make check-in as smooth as possible for all. We thank you for your help in this effort!

In the spirit of camping,
The Staff at Camp Burgess & Hayward

CAMPER HEALTH FORM

South Shore YMCA
Camp Burgess & Hayward
75 Stowe Rd. • Sandwich • MA • 02563
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 May 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 mes 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: _____

Please continue to next

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.

Please continue to next page

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?	**☐ Yes**	**☐ No**

(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

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.***

Please continue to next page

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 SUBSITUTED, 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
Diptheria, 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

Camper Information Form

South Shore YMCA
Camp Burgess & Hayward
75 Stowe Rd. Sandwich • MA • 02563
508-428-2571
www.ssymca.org

To enable our staff to help your child have a meaningful experience,
please complete this form and upload to your child's account.

Having prior knowledge about any concerns you have for your child makes a difference in helping us be sensitive to your child's need for patience, understanding and reassurance - especially in the first few days of Camp!

Children often use their behavior rather than words to tell us something is bothering them. Having advance knowledge of areas that might be difficult for your child helps us understand the message in his or her actions. Our commitment is to use the information only to help your child adjust to Camp. The information you provide will be kept in the strictest confidence.

If you would like to speak with the Camp Director about this request, call us at 508-428-2571.

BOTH SIDES OF THIS FORM ARE MANDATORY

Camper's Name: _____ ☐ Male ☐ Female

Current School Grade: _____ Age When At Camp: _____

Please circle session(s) : 1 1a 1b 2 3 4 Co-ed Camp

Has your child ever attended our Camp before? ☐ Yes ☐ No

If yes, how many summers?_____

If no, how did you hear about our Camp?_____

If no, has your child ever been away from home before? ☐ Yes ☐ No For how long? _____

Who does your child live with at home? _____

What specific activities is your child most looking forward to?

What interests/hobbies/activities is your child interested in at home?

Please complete page 2 also!

Name: _____ Session: 1 1a 1b 2 3 4 Co-ed

How well does your child relate to new experiences, places and friendships?

Please check any concerns you have about your child:

□ Fears	□ Bed-wetting	□ Nightmares
□ Homesickness	□ Home-life	□ Sleepwalking
□ Allergies	□ Behavior	□ ADD/ADHD
□ Anxiety	□ Other _____	

Please explain your concern(s) below and inform us of how our staff can help:

Is there any other information that would be helpful for us to know about your child?