

Pilgrim Day Camp

1 Badger Road, Framingham, MA 01702
Summer: 508-875-8215 • Winter: 508-875-4548
Fax: 508-872-8154 • Winter Fax: 508-875-5485

2012 Application

Please print and sign one form per child. \$100 deposit per child per session. \$25 registration fee per child.

Name _____

Mailing Address _____

Gender (please ✓ one) M F

Birth Date (mm/dd/yy) _____/_____/_____ Age (as of June 1st) _____

Did camper attend Pilgrim Day Camp in 2011, if so what group? (please ✓ one) Yes No

Session Information (please put a ✓ in the box next to the session(s) your child will attend)

Session 1

June 25th - July 6th

- Full Day - \$522
- Half Day Morning- \$340
- Half Day Afternoon - \$340
- Extended Morning - \$80
- Extended Afternoon (1 hr) - \$80
- Extended Afternoon (2 hr) - \$160
- Transportation - \$160
- CIT Program - \$260
- First week only- \$325
- Second week only- \$325

Session 2

July 9th - July 20th

- Full Day - \$580
- Half Day Morning- \$375
- Half Day Afternoon - \$375
- Extended Morning - \$85
- Extended Afternoon (1 hr) - \$85
- Extended Afternoon (2 hr) - \$165
- Transportation - \$185
- CIT Program - \$290
- First week only- \$325
- Second week only- \$325

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Session 3

July 23rd - August 3rd

- Full Day - \$580
- Half Day Morning- \$375
- Half Day Afternoon - \$375
- Extended Morning - \$85
- Extended Afternoon (1 hr) - \$85
- Extended Afternoon (2 hr) - \$165
- Transportation - \$185
- CIT Program - \$290
- First week only- \$325
- Second week only- \$325

Session 4

August 6th - August 17th

- Full Day - \$580
- Half Day Morning- \$375
- Half Day Afternoon - \$375
- Extended Morning - \$85
- Extended Afternoon (1 hr) - \$85
- Extended Afternoon (2 hr) - \$165
- Transportation - \$185
- CIT Program - \$290
- First week only- \$325
- Second week only- \$325

I hereby agree to comply with the terms stated on this registration and the accompanying brochure in consideration of acceptance of my child as a camper at Pilgrim Day Camp. Permission is hereby given for the use of any films or photographs of my son/daughter for camp publicity purposes.

Parent Signature: _____ **Date:** _____

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Health Information

Parent Information - Parent 1

Name _____
Mailing Address _____
Street Address _____
Town _____
Home Phone () _____
Cell Phone () _____
Work Phone () _____
Parent Email _____

Parent Information - Parent 2

Name _____
Mailing Address _____
Street Address _____
Town _____
Home Phone () _____
Cell Phone () _____
Work Phone () _____
Parent Email _____

Emergency Contact - 1

Name _____
Home Phone () _____
Cell Phone () _____
Relation to Camper _____

Emergency Contact - 2

Name _____
Home Phone () _____
Cell Phone () _____
Relation to Camper _____

Current Health Information

Please describe any current physical or emotional condition requiring special consideration while at camp:

Allergies

Please put a check in the box next to all that apply and then specify.

(For example, if your child has a peanut allergy, check the box next to "food" and then write peanut.)

Seasonal

Medication

Other

Bee

Food

Does the camper use an Epi-pen? Yes No

If yes, Epi Jr or Epi Adult _____

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Health Information

Health History

The following information must be filled in by the parent/guardian or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a completed form for your records. Any changes to this form should be provided to the camp health personnel upon participant's arrival at camp. Provide complete information so that the camp can be aware of your needs.

Does the camper have or has the camper had:

- | | | | |
|--|--|---|--|
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | ADD or AD/HD | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| A disability or chronic or recurring illness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental/emotional health concerns | |
| Operations or serious injuries | <input type="checkbox"/> Yes <input type="checkbox"/> No | diagnosed by a professional | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease/Defect | <input type="checkbox"/> Yes <input type="checkbox"/> No | A significant life event continuing to affect | |
| Convulsions/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | the camper's life (abuse, death, adoption, | |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | new sibling, disaster, etc) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding/Clotting | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Please explain "yes" answers and how they might affect your child's safe participation in camp activities?

Please list all medications your child is currently taking:

Insurance

Do you carry family medical/hospital insurance? Yes No

We are unable to accept this form without insurance company and policy or group number. Please provide this information below:

Name of Insurance Company: _____ Policy or Group # _____

Does your child have an allergy that may require a trained camp employee to administer an Epi-Pen or an antihistamine (e.g. Benadryl)? Yes No

If yes, please have **your physician fill out and sign the allergy action plan on the next page**. Please know that any child with an allergy **MUST** have our allergy action plan submitted and signed by their pediatrician prior to their first day of camp.

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Allergy Action Plan - USE 1 FORM PER CHILD FOR EACH ALLERGEN. WE WILL ONLY ACCEPT OUR ACTION PLAN!

Camper: _____

Allergy to: _____

Asthmatic? Yes* No *Higher risk for severe reaction

Step 1 - Treatment

SEND CAMPER TO HEALTH OFFICE ACCOMPANIED BY RESPONSIBLE PERSON.

The severity of symptoms can quickly change. Symptoms underlined below are potentially life threatening.

Symptoms

If a camper has been exposed to/ingested an allergen but has NO symptoms:

Mouth - Itching, tingling, or swelling of lips, tongue, mouth:

Skin - Hives, itchy rash, swelling of the face or extremities:

Gut - Nausea, abdominal cramps, vomiting, diarrhea:

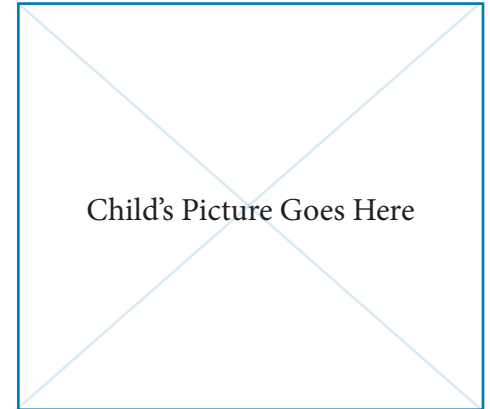
Throat - Tightening of throat, hoarseness, hacking cough:

Lung - Shortness of breath, repetitive coughing, wheezing:

Heart - Thready pulse, low blood pressure, fainting, pale, blueness:

Other _____

If reaction is progressing, (several of the above areas affected), give:



Give Checked Medication**

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

Important: Asthma inhalers and/or antihistamines cannot be depended upon to replace epinephrine in anaphylaxis.

Epinephrine: Inject intramuscularly.

EpiPen®

Twinject 0.3mg

EpiPen® Jr.

Twinject 0.15mg

Antihistamine: Give _____
antihistamine/dose/route

Other: Give _____
antihistamine/dose/route

Special Instructions (for Physician to complete): _____

Parent Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

(required)

**Determined by physician authorizing treatment

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Health Information

Parent Authorization to Administer Medication Form

(One medication per page! You may make copies of this page and add those pages to this application.)

*You only need to fill out this form if you are bringing in any medication from home that the health office staff will need to administer during camp hours (i.e. Epi Pens, antihistamines, ADHD medications, etc). Medication must be in its original packaging. If it's a prescribed medication, it must have the prescription on the bottle. Only parents/guardians are allowed to bring medication to the health office. Campers are not allowed to do so.

Date: _____ Unit: _____ Camper's Name: _____

Parent's Name: _____ Parent's Home Phone: _____

Mom's Work Phone: _____ Mom's Cell Phone: _____

Dad's Work Phone: _____ Dad's Cell Phone: _____

Other person to notify in case of emergency: _____ Relation: _____

Other's Phone Numbers Home: _____ Work: _____ Cell: _____

Prescribing Physician

Name: _____ Phone Number: _____

Allergies: _____

Medication: _____ Dose: _____ Route (i.e. by mouth): _____

Frequency: _____ Date Ordered: _____ Duration of Order: _____

Quantity Received: _____ Specific Directions (i.e. take on empty stomach): _____

Reason for Medication: _____

Time to be Given: _____

How does your child best take this medication? (i.e. with water) _____

I authorize the PDC health personnel and/or their designee to administer the above named medication to my child.

Parent Signature: _____

Please put a check mark in the box below and sign below it if you authorize your child's camp counselor(s) to carry their medication (i.e. Epi Pen, Antihistamine, or inhaler, etc.) in their back pack.

Parent Signature: _____

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Dietary and/or Activity Restrictions: Yes No List restrictions: _____

Authorization for over-the-counter (OTC) medication: If you wish to allow the camp nurse to be able to administer OTC medication, please check off those you will allow. Please note that our camp physician has provided age-appropriate dosages for each medication:

Tylenol Ibuprofen Benadryl Other _____

Precautions or limitations: _____

I hereby request and authorize the camp nurse to administer the medication designated above.

Signature: _____ Date: _____

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the nurse and the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Parent Guardian Signature: _____ Date: _____

A copy of the participant's most recent physical examination and immunization record is REQUIRED. If not received by the first day of camp, the participant will not be able to participate in camp. Please make a photocopy of the immunization record and send it in WITH this form. Confirmation will not be sent until this form is received.

*If vaccination or immunization conflicts with your sincere religious beliefs, a formal letter to that effect is required.