Camp STAR Angelina Camper Application

Summer 2018

This camp must comply with regulations if Massachusetts Dept. of Public Health and be licensed by the Local Board of Health

Camper Information

Please go to our website or come to the Recreation Office to pick up a family handbook and camp calendar. One camper per application.

Camper's Name: _____ Male / Female _____

Mailing Address: _____
(Street) (City) (State) (Zip)

DOB: _____ Age: _____ School _____Grade _____

Camp Shirts: Please circle one

Youth Sizes XS S M L **Adult Sizes** XS S M L XL XXL

Parent / Guardian Name 1: _____

Email: _____Phone: _____

Parent / Guardian Name 2: _____

Email: _____Phone: _____

Does your camper require transportation? **Yes / No**

Pick up / drop off address (needs to be the same location)

_____
(Street) (City) (State) (Zip)

If applicable:

Agency/Organization: _____ Phone: _____

Address: _____ Phone: _____

Social Worker: _____Email: _____

Please check the appropriate box(es)

X	Session	Session Dates	Springfield Resident Fees	Non-Springfield Resident Fees
	Session 1	Mon July 2nd – Friday July 13th (No camp July 4th)	$250	$475
	Session 2	Mon July 16th – Fri July 27th	$250	$475
	Session 3	Mon July 30th – Fri August 10th	$250	$475
	All Sessions:	Mon July 2nd – Fri August 10th	$750	$1425

Please make checks or money orders payable to: **City of Springfield / CSA**
All information can be sent to Camp STAR Angelina (CSA), Attention: Krista Stott, 200 Trafton Rd. Springfield, MA 01108

_____

You will not be registered for camp until all information and payment is received. Once we receive all information, camper acceptance letters will be sent home. If you do not receive an acceptance letter then your camper has not been registered for camp due to missing information or payment. Please get your information in quickly. There are a limited amount of spots available for age groups. Once these spots are filled, campers will be placed on a waiting list.

Questions	Yes	No	Explain
Has your camper attended Camp STAR Angelina?			
Has your camper attended a different camp?			
Does your camper speak English?			
Is your camper independent in toileting?			
Can your camper swim without a floatation device?			
If transportation were not provided, would your camper still be able to attend camp?			

The staff to camper ratio is 1:5, however 1-to-1 staff to camper ratios can be provided if needed. Does your camper require from a 1:1? **Yes /No**

Please list / describe any medical condition (s) of the camper or other information you feel is important for staff to know:

_____

_____

Medical Information

Camper Name: _____ DOB _____

Do any of the following apply to your camper?

Condition	Yes	No	Explain
Seizure Disorder			
Physical Disability			
Hearing Impairment			
Visual Impairment			
Heart Condition			
Asthma			
Diabetes			
ADHD / ADD			
Behavior Concerns			
Phobias			
Medical Restrictions			
Triggers			
Uses an assisted device			
Verbal			
IEP/504 Plan			
Other			

Please list any goals your camper may have for the summer:

_____

_____

Camper's Name: _____ DOB: _____

Emergency Contact Information

In Case of Emergency

Parent / Guardian: _____ Phone: _____

Parent / Guardian: _____ Phone: _____

In Case of Emergency (other than parent /guardian)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Insurance Information

Primary Insurance: _____Policy Number: _____

Primary Doctor: _____ Phone Number: _____

Address: _____

Camper Release

We will not release your camper to anyone not indicated below. Identification is required. Please include parent / guardian.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Permissions

Camper's Name: _____ DOB: _____

Please initial the following:

_____ I hereby give permission to Camp STAR Angelina to photograph my camper; I understand that the photographs may be used for news media.

_____I hereby give permission for my camper to go on field trips if and when one occurs while attending camp.

_____I hereby give permission for my camper to use swimming facilities and participate in the swim program during camp.

_____ I understand that I must read and abide by the program requirements included in the family handbook.

_____ I agree that my camper be assisted in taking the medication(s) as prescribed by the PCP/NP during camp hours by an authorized person prescribed by PCP/NP and authorized by me.

_____ I give my permission for the camp nurse and staff to apply sunscreen and/or bug spray.

_____ I give permission for my camper to walk home.

My camper has permission to participate in activities provided by agencies participating in the Recreation/Camp STAR Angelina program. I acknowledge that my camper must follow all the rules in order to participate. In the event that I cannot be reached in an emergency I hereby authorize the medical/surgical treatment be administered to my camper at my expense. I assume all risks and hazards incidental to and inherent in participation in this program. I hereby waive and release the City of Springfield and its officials, employees and officers from any claims that arise out of a decision to authorize medical/surgical treatment, as well as claims arising out of any personal injury or property damage related in any way to my camper's participation in the program. I hereby indemnify and hold harmless those agencies or organizations providing activities for Camp STAR Angelina program from claims of third parties arising out of the decision to authorize medical/surgical treatment, or my camper's participation in the program. My signature certifies that I have read and understood this disclaimer, and all the program rules and regulations.

_____ _____

Print Name Date

_____ _____

Parent / Guardian Signature Date

Camp STAR Angelina

Authorization to Administer Medication to a Camper

(Completed by parent/guardian)

Camper and Parent/Guardian Information	
Camper's Name:	
Age:	Food/Drug Allergies:
Diagnosis (at parent/guardian discretion):	
Parent/Guardian's Name:	
Home Phone:	Business Phone:
Emergency Telephone:	
Licensed Prescriber Information	
Name of Licensed Prescriber:	
Business Phone:	Emergency Phone:
Medication Information 1	
Name of Medication:	
Dose given at camp:	Route of Administration:
Frequency:	Date Ordered:
Duration of Order:	Quantity Received:
Expiration date of Medication Received:	
Special Storage Requirements:	
Special Directions (e.g., on empty stomach/with water):	
Special Precautions:	
Possible Side Effects/Adverse Reactions:	
Other medications (at parent/guardian discretion):	
Location where medication administration will occur:	
Medication Information 2	
Name of Medication:	
Dose given at camp:	Route of Administration:

Frequency:	Date Ordered:
Duration of Order:	Quantity Received:
Expiration date of Medication Received:	
Special Storage Requirements:	
Special Directions (e.g., on empty stomach/with water):	
Special Precautions:	
Possible Side Effects/Adverse Reactions:	
Other medications (at parent/guardian discretion):	
Location where medication administration will occur:	

Authorization Information

I hereby authorize the health care consultant or properly trained health care supervisor at Camp STAR Angelina to administer, to my child, _____ the
(name of camper)
medication(s) listed above, in accordance with 105 CMR 430.160(C) and 105 CMR 430.160(D) [see below].

If above listed medication includes epinephrine injection system:
I hereby authorize my child to self-administer , with approval of the health care consultant □ Yes □ No □ Not Applicable

I hereby authorize an employee that has received training in allergy awareness and epinephrine administration to administer
□ Yes □ No □ Not Applicable

If above listed medication includes insulin for diabetic management:
I hereby authorize my child to self-administer , with approval of the health care consultant □ Yes □ No □ Not Applicable

Signature of Parent/Guardian:	Date:

Health Care Consultant at a recreational camp is a Massachusetts licensed physician, certified nurse practitioner, or a physician assistant with documented pediatric training.
Health Care Supervisor is a staff person of a recreational camp for children who is 18 years old or older; is responsible for the day to day operation of the health program or component, and is a Massachusetts licensed physician, physician assistant, certified nurse practitioner, registered nurse, licensed practical nurse, or other person specially trained in first aid.

Camp STAR Angelina

Authorization to Administer Medication to a Camper

I hereby authorize Camp STAR Angelina to administer, to my child, _____ the medication(s) 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)
A written policy for the administration of medications at the camp shall identify the individuals who will administer medications. This policy shall:
(1) List individuals at the camp authorized by scope of practice (such as licensed nurses) to administer medications; and/or other individuals qualified as health care supervisors who are properly trained or instructed, and designated to administer oral or topical medications by the health care consultant.
(2) Require health care supervisors designated to administer prescription medications to be trained or instructed by the health care consultant to administer oral or topical medications.
(3) Document the circumstances in which a camper, Heath Care Supervisor, or Other Employee may administer epinephrine injections. A camper prescribed an epinephrine auto-injector for a known allergy or pre-existing medical condition may:
a) Self-administer and carry an epinephrine auto-injector with him or her at all times for the purposes of self-administration if:
1) the camper is capable of self-administration; and
2) the health care consultant and camper's parent/guardian have given written approval

(b) Receive an epinephrine auto-injection by someone other than the Health Care Consultant or person who may give
injections within their scope of practice if:
1) the health care consultant and camper's parent/guardian have given written approval; and
2) the health care supervisor or employee has completed a training developed by the camp's health care consultant in accordance
with the requirements in 105 CMR 430.160.
(4) Document the circumstances in which a camper may self-administer insulin injections. If a diabetic child requires his or her blood sugar be monitored, or requires insulin injections, and the parent or guardian and the camp health care consultant give written approval, the camper, who is capable, may be allowed to self-monitor and/or self-inject himself or herself. Blood monitoring activities such as insulin pump calibration, etc. and self-injection must take place in the presence of the properly trained health care supervisor who may support the child's process of self-administration.

105 CMR 430.160(F)
The camp shall dispose of any hypodermic needles and syringes or any other medical waste in accordance with 105 CMR 480.000: Minimum Requirements for the Management of Medical or Biological Waste.

105 CMR 430.160(I)
When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be disposed of as follows:
(1) Prescription medication shall be properly disposed of in accordance with state and federal laws and such disposal shall be documented in writing in a medication disposal log.
(2) The medication disposal log shall be maintained for at least three years following the date of the last entry.

*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 Name: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

Please send in a copy of a physical (within 18 months) and immunizations with the application. It is required to participate in camp.

Household Information

Camp receives money from Community Development each year to help with camp costs. Please fill out the information below.

Family Status:
Female Head of Household ____
Male Head of Household: ____
Two Parent Head of Household: ____

Number of family members (parents & campers): _____

Parent / Guardian's Name: _____ Phone: _____

Parent / Guardian's Name: _____ Phone: _____

Please fill out chart below: For example if you have two people (mother and son) and your income is $22,000 then you would go to the 2 person's row and mark the 20,001-33,000 spot.

Household	**Extremely Low (30%) Income Limits**	**Very Low (50%) Income Limits**	**Low (80%) Income Limits**
1 person	_____$16,950	_____$16,951 - 28,250	_____$28,251 – 45,200
2 persons	_____$19,400	_____$19,401-32,300	_____$32,301-51,650
3 persons	_____$21,800	_____$21,801-36,350	_____$36,351-58,100
4 persons	_____$25,100	_____$25,101 -40,350	_____$40,351-64,550
5 persons	_____$29,420	_____$29,421 -43,600	_____$43,601-69,750
6 persons	_____$33,740	_____$33,741-46,850	_____$46,851-74,900
7 persons	_____$38,060	_____$38,061-50,050	_____$50,051-80,050
8 persons	_____$42,380	_____$42,381-53,300	_____$53,301-85,250

Ethnicity: Hispanic / Latino _____ Non-Hispanic / Latino _____

Please check off one:

White		Asian		Amer. Indian/Alaskan Native & White	
Black / African Amer.		Asian & White		Amer. Indian/Alaskan Native/Black/African Amer.	
Black/African Amer. & White		Asian / Pacific Islander		Native Haw. /Other Pacific Islander	
Hispanic White		Hispanic Black		Amer. Indian / Alaska Native	

Other multi-racial (please list): _____

Parent /Guardian Signature: _____Date: _____