Camp STAR Angelina Application for Summer 2016

Camper Information:

Camper's Name: _____ DOB: _____ Age: _____

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

Camper's School: _____ Grade: _____ Male / Female Shirt Size: _____

Does your child require transportation? Yes / No (Both pick up / drop off need to be the same address)

Pick up / drop off address (If different from above): _____
(Street) (City) (State) (Zip)

Doctor's Office: _____ Doctor's Name: _____ Phone: _____

Health Insurance Company: _____ Policy # _____

Agency: _____ Social Worker: _____ Phone: _____

Session One (July 5 – July 22): _____ Session Two (July 25 – August 12): _____
Residents $300 for one session, $500 for two (includes transportation)
Non-residents $1500 for one session, $3100 for two sessions (does not include transportation)
Checks & Money Orders are the only form of payment accepted: Please make checks payable to: Parents & Friends of STAR Inc.

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Question	Yes	No	Explain / List
Has your camper attended camp before?			
Does your camper speak English?			
Does your camper take medications?			
Does your camper have allergies?			
Is your camper independent in bath rooming?			
Does your camper have medical restrictions?			
Does your camper attend special classes in school?			
Does your camper receive PT, OT, or speech in school?			
Does your camper have any specific behavior concerns?			
Does your camper use assistive devices?			
Does your camper have any program restrictions?			

Additional Comments:

_____

_____

_____

Child Release Permissions:

****We will not release your child to anyone not indicated below. Identification is required.**
Person(s) other than parents authorized to take a child from camp (if any). Please list all.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Hospital Release:

In the event my camper needs emergency medical care while in program Camp STAR Angelina, I hereby give permission for the hospital to give such emergency treatments as are considered necessary or desirable by medical judgment, including administration of anesthesia. I agree to assume all medical expenses incurred by my camper while under the supervision of Camp STAR Angelina.

Signature: _____ Date: _____

Various Releases: (Please initial)

_____ 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 while attending camp.

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

_____ I hereby give permission for my camper to ride in the City's vans.

_____I hereby give permission for the Springfield Parks Department to release my name, address and phone to the Parents & Friends of Star parents group. This group is concerned with the well-being of the program and may need your help at a future date.

_____ I have received and read the family handbook.

Household Information: This section must be filled out completely.

Guardian's Name: _____ Phone: _____ E-mail: _____

Guardian's Name: _____ Phone: _____ E-mail: _____

Camp receives money from Community Development each year and we are **required** to provide a self-declaration of the following:
Please check off the appropriate response for each question below or your child may not be admitted.
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	_____$17,500	_____$17,501-29,150	_____$29,151-46,000
2 persons	_____$20,000	_____$20,001-33,000	_____$33,001-52,600
3 persons	_____$22,500	_____$22,501-37,450	_____$37,451-59,150
4 persons	_____$24,950	_____$24,951-41,600	_____$41,601-65,700
5 persons	_____$28,440	_____$28,441-44,950	_____$44,951-71,000
6 persons	_____$32,580	_____$32,581-48,300	_____$48,301-76,250
7 persons	_____$35,730	_____$36,731-51,600	_____$51,601-81,500
8 persons	_____$40,890	_____$40,891-54,950	_____$54,951-86,750

Family Status: Female Head of Household _____ Male Head of Household: _____ Two Parent Head of Household: _____
Number of family members (parents & children): _____**Ethnicity:** Hispanic / Latino _____ Non-Hispanic / Latino _____

Please check off one:

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

Other multi-racial (please list): _____

Camp STAR Angelina

Prescription / Medication Form

Standard medication order form for ALL medications administered during camp hours.

Must be completed by a Physician / Nurse Practioner

Camper Name:_____D.O.B._____Gender:_____

Medication	Dosage	Route	Time	Diagnosis	Side Effects

If there is a Rx is for an inhaler or Epi-Pen, can this camper self-administer? Yes _____ No _____

Physician /Nurse Practitioner Name:

_____ _____ _____

(Print) (Signature) (Date)

Please provide physician's office stamp in space provided:

Must be completed by a Parent / Guardian

_____ I agree that my camper be assisted in taking the above medication(s) as prescribed by the PCP/NP during camp hours by an authorized person or is permitted to self-medicate themselves as prescribed by the physician and authorized by me.

_____I give my permission for the camp nurse to discuss with the prescriber and camp staff any necessary information on this form.

Field trips run from 10 -2:30pm and nursing coverage will not be available. Please choose one.

____I give permission that medication be given before or after by the nurse on field trip days.

____ I give permission that medication is given by camp staff during the field trip.

____ I do not wish for my camper to attend field trips due to his/her medication.

Parent / Guardian Signature: _____ Date: _____

Camp Nurse Signature: _____ Date: _____

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name _____ ☐ Male ☐ Female Date of Birth: _____

Medical History _____

Pertinent Family History

Current Health Issues

Y N

☐ ☐ Allergies: Please list: Medications _____ Food _____ Other _____

History of Anaphylaxis to _____ Epi-Pen®: ☐ Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure disorder: _____

☐ ☐ Other (*Please specify*) _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination Date of Examination: _____

Hgt: _____ (____%) Wgt: _____ (____%) BMI: _____ (____%) BP: _____

(Check = Normal / If abnormal, please describe.)

☐ General _____ ☐ Lungs _____ ☐ Extremities _____

☐ Skin _____ ☐ Heart _____ ☐ Neurologic _____

☐ HEENT _____ ☐ Abdomen _____ ☐ Other _____

☐ Dental/Oral _____ ☐ Genitalia _____

Screening:

	(Pass)	(Fail)		(Pass)	(Fail)		(Pass)	(Fail)
Vision: Right Eye	☐	☐	Hearing: Right Ear	☐	☐	Postural Screening:	☐	☐
Left Eye	☐	☐	Left Ear	☐	☐	(Scoliosis/Kyphosis/Lordosis)		
Stereopsis	☐	☐						

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other _____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors);

Date of PPD: ____; Results: ____mm.

Referred for evaluation to: _____ ☐ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit

☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations:

☐ Y ☐ N This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions: _____

☐ Y ☐ N Immunizations are complete; if no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.

_____ _____

Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____

Group Practice Telephone

_____

Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 12/14/04*