

REGISTER ONLINE AT www.4hcampct.org
CAMP APPLICATION - 2024 WINDHAM-TOLLAND 4-H CAMP - FORM A

Camper's Name (Last Name) _____ (First Name) _____

Mailing Address _____, Town _____, State _____, Zip Code _____

Boy _____ Girl _____ Date of Birth (Month, Day, Year) _____ Age _____ School Grade in Sept., 2024 _____

Parent/Guardian's Name _____ Email Address _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Please circle your choice below:

RESIDENT (Overnight) CAMP DAY CAMP (Sunday Check-in 2:30pm-4pm) ½ Week CLOVER CAMP A, C, E, or G ½ Week CLOVER CAMP B, D, F, or H Full Week CLOVER CAMP I, J, & K	Sun 2:30 PM – 4 PM thru Fri 7 PM Mon thru Fri - 8-8:30 AM – 5-5:30 PM Sun. 2:30pm thru Tues 5 PM Wed. 8:00 AM thru Fri 7 PM Same Schedule As Resident Camp	(Boys & Girls, Ages 9-15) (Boys & Girls, Ages 6-15) (Clover Boys & Girls, Ages 7-8) (Clover Boys & Girls, Ages 7-8) (Clover Boys & Girls, Ages 7-8)
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Circle your week choice(s):						Special Activities (add'l Fees Apply)	
WEEK 1 –Medieval Wk <i>June 23 – June 28</i>	RES \$585	DAY \$375	CLOVER A 6/23 - 6/25 Sun - Tues \$310	CLOVER B 6/26 – 6/28 Wed - Fri \$310	COW CAMP \$25	(9+ Yrs Old) Wood fiber Crafts \$30	(9+ Yrs Old) Riding + \$250
WEEK 2 – Minecraft Wk <i>June 30 – July 5</i>	RES \$585	DAY \$375	CLOVER C 6/30 – 7/2 Sun – Tues \$310	CLOVER D 7/3 – 7/5 Wed – Fri \$310		Wood fiber Crafts \$30	Riding + \$250
WEEK 3 – Carnival Wk <i>July 7 - July 12</i>	RES \$585	DAY \$375	CLOVER E 7/7 – 7/9 Sun – Tues \$310	CLOVER F 7/10 – 7/12 Wed - Fri \$310		Wood fiber Crafts \$30	Riding + \$250
WEEK 4 – Winter Extravaganza Wk <i>July 14 - July 19</i>	RES \$585	DAY \$375	CLOVER G 7/14 – 7/16 Sun - Tues \$310	CLOVER H 7/17– 7/19 Wed- Fri \$310		Wood fiber Crafts \$30	Riding + \$220
WEEK 5 – Olympic Wk <i>July 21 - July 26</i>	RES \$585	DAY \$375	Clovers I \$585			Wood fiber Crafts \$30	Riding + \$250
WEEK 6 – International Wk <i>July 28 – August 2</i>	RES \$585	DAY \$375	Clovers J \$585			Wood fiber Crafts \$30	Riding + \$250
WEEK 7– Tropical Paradise Wk <i>August 4 - August 9</i>	RES \$585	DAY \$375	Clovers K \$585			Wood fiber Crafts \$30	Riding + \$250
WEEK 8 – Capture the Flag Wk <i>August 12 – August 16</i>	DAY CAMP ONLY \$375						

A CONFIRMATION LETTER TO EACH CAMPER WILL BE MAILED AFTER YOUR REGISTRATION IS PROCESSED. I understand that there is \$200.00 deposit for Resident Camp and Experience Clovers, a \$100.00 deposit for Day Camp and Teen Leaders and a \$50.00 deposit for Clover Camp and Horseback Riding. **No refunds after May 21, 2024.** I also understand there are NO REFUNDS FOR EARLY DISMISSAL DUE TO HOMESICKNESS, MISCONDUCT OR MEDICAL REASONS (please see website for complete refund policy).

PAYMENT METHOD: A deposit for each camper per week per session is required.

- ☐ Check/ money order enclosed payable to: Windham-Tolland 4-H Camp. Amount: \$ _____
- ☐ VISA/Discover/MasterCard # _____ Exp. Date _____ Amount: \$ _____

I wish to bunk with (MAXIMUM OF ONE CAMPER ONLY) _____, age _____ (MUST BE SAME AGE). **Both friends must request each other on their applications.** Applications with more than one person requested for bunking will not be accepted.

 Signature of Parent/Guardian

 Cardholder Signature (if paying by credit card)

Date _____

FORM B (Please return with Forms A, B, C, D, E, F & G)

WINDHAM-TOLLAND 4-H CAMP
CODE OF CONDUCT AGREEMENT
FOR CAMPERS, TEEN LEADERS AND PARENTS

I, the undersigned camper/teen leader and parent/legal guardian have read the basic rules for participation at the Windham-Tolland 4-H Camp program outlined below and agree to abide by the rules.

Campers will:

- Participate fully in the program.
- Be responsible for his/her own behavior and uphold standards for their peers.
- Follow all scheduled times, including curfew and wake-up.
- Will dress appropriately for a co-ed outdoor recreation experience.

Campers will not:

- Leave the camp premises without staff supervision and director permission.
- Disobey directives from camp staff or camp policies, rules and regulations.
- Be disrespectful or direct profanity, vulgar language, or obscene gestures towards other campers or camp staff or wear offensively worded or graphic clothing.
- Play with matches, fire, or commit arson.
- Partake in the theft or the unauthorized removal of camp property, staff property or camper property.
- Fight, provoke fighting or commit physical abuse to others or themselves.
- Commit extortion, coercion or blackmail that force an individual(s) to act through the use of force or threat of force.
- Make derogatory statements that may substantially disrupt the camp program or insight violence.
- Engage in sexual harassment: any unwelcome sexual advance or conduct including lewd remarks, touches, or request for sexual favors that have the effect of intimidating individuals or disrupting the camp environment will not be tolerated.
- Sell, give, deliver, possess, use or be under the influence of drugs, alcohol or tobacco products. This includes the misuse of prescription and over the counter medications. **THIS INCLUDES ALL VAPING.**
- Haze other campers.
- Possess a weapon or dangerous instrument to be used as a weapon.
- Violate local, state or federal laws.
- Intentionally damage camp facilities including graffiti; you will be billed for damages.
- Bring electronic equipment including but not limited to: cell phones, CD players, MP3 players, iPods, iWatches, video games, radios, Kindles and Nooks or other electronic devices.

- Failure to comply with these rules may result in but not be limited to a "time-out" from an activity, removal from a program area or expulsion from the camping program. Corporal Punishment is not permitted at the Windham-Tolland 4-H Camp. Violations of local, state or federal laws will be reported to the authorities.
- I understand that there is a \$200.00 deposit for Resident Camp and Full Week Clovers, a \$100.00 deposit for Day Camp and Teen Leaders and a \$50.00 deposit for ½ week Clover Camp and Horseback Riding. There are NO REFUNDS AFTER May 21, 2024. I also understand there are NO REFUNDS FOR EARLY DISMISSAL DUE TO HOMESICKNESS, MISCONDUCT OR MEDICAL REASONS. (please see website for complete refund policy)
- **PERMISSION FORM - Complete a separate application form for each child.** I hereby give permission for the named camper to attend the Windham-Tolland 4-H Camp and to participate in all activities, subject to the authority of the camp director. I further give permission for the named camper to participate in any planned out-of-camp outings or trips under the supervision of the director or assigned staff member. I will not hold the Windham-Tolland 4-H Camp responsible for the loss of money, jewelry, or personal articles brought to camp. I also give my permission for use of any photo of the named camper to be used by the Camp Committee for camp public relations.

Optional Information:

Ethnicity: _____ Hispanic or Latino _____ Not Hispanic or Latino
Race: _____ White _____ Black/African American _____ Asian
_____ American Indian/Alaskan Native _____ Native Hawaiian/Pacific Islander

BOTH CAMPER AND PARENT/ LEGAL GUARDIAN MUST SIGN THIS CODE OF CONDUCT.

Signature of Camper

AND

Signature of Parent/ Legal Guardian

Date :

CAMPER INFORMATION MEDICAL FORM – FORM C

Camper's Full Name _____
DOB _____ Age _____ Home Ph _____
Address _____ City _____ State _____

Parent/Guardian #1 _____ Relationship _____
Cell Ph _____ Work/Other Ph _____
Email _____

Parent/Gaurdian#2 _____ Relationship _____
Cell Phone _____ Work/Other Ph _____
Email _____

Name of additional emergency contact(s):

_____ Ph _____ Relationship _____
_____ Ph _____ Relationship _____

Health Insurance Company _____
Insurance Policy # _____
Insurance carried by _____ Employer _____

HEALTH HISTORY

Date of Last Physical Exam: _____ ******Must be within last 2 years and provided to camp. ******

Last Tetanus Immunization: _____

Primary Care Physician : _____ Phone: _____

Current weight _____ Current height _____

PERMISSION TO TREAT

Connecticut law states that except in the case of an emergency which threatens life or limb, parent or guardian must sign consent to treat for a patient under the age of 18. Please complete this section to allow your camper to receive treatment for accident, injury or illness at a medical facility.

- Camper be will transported to nearest hospital, Day Kimball Hospital in Putnam, CT
- On stay-over weekend, camper will be brought to hospital nearest to field trip location.
- Camp staff will always notify parent/guardian of need for medical care.
- Camper Health History and Registration Forms will be shared with Medical Facility.

I request and authorize, Day Kimball Hospital, or nearest medical center, and its personnel to deliver medical care to my child listed here: _____. I also authorize the Windham Tolland 4-Camp to share Camper and Health History with the Medical Provider. This authorization will expire one year from date of signature unless otherwise stated.

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed camp activities except as noted. **EMERGENCY AUTHORIZATION:** I hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine tests and treatment for me(staff) or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure treatment for and to order injection and/ or anesthesia and/or surgery for me(staff)/or my child as named above. This form may be photo-copied for use out of camp. I also give permission for the camp to provide routine medical care for my child.

Signature (Parent/Guardian/Adult Staff Member)

Date

Printed Name (Parent/Guardian/Adult Staff Member)

Relationship to camper

Name: _____

Age: _____

FORM D – PLAN OF CARE

The following questions are required for ALL campers. This plan of care is to help maintain health and maximize camper participation in the camp program. Please complete this form even if your child has no official diagnosis.

PLEASE CHECK ALL THAT APPLY AND COMPLETE APPLICABLE SECTIONS:

___ My child has a food allergy(s) to: _____

___ My child has non-food allergy(s) to: _____

The plan of care is ___ Avoidance

___ Medication as ordered. Please attach doctor's order.

___ Other, please specify _____

___ My child requires medication for treatment of _____

Please attach doctors' orders, **CAMP FORM E** or school form is acceptable.

___ My child has special dietary, dental or oral needs: _____

The plan of care is _____

___ My child is ___ hearing or ___ vision impaired.

The plan of care is _____

___ My child as a chronic illness or diagnosis of _____

The plan of care is _____

___ My child has cognitive, emotional and/or physical developmental needs related to the diagnosis of :

The best way to support my child with this is to : _____

___ My child has had a serious illness, hospitalization or accident in the last 12 months. Please explain. _____

___ My child has required psychiatric counseling/hospitalization. _____

___ Any Specific activities to be limited by physician's advice. (Send with Physician's orders)

___ **Check here to be contacted by Camp Nurse or Camp Director to further discuss and plan for the needs of your child. Please indicate best number or email for contact** _____

___ My child DOES NOT require any plan of care for special health needs.

Parent/Guardian Signature

Date

THIS FORM REQUIRES PHYSICIAN'S SIGNATURE
AND PARENT/GUARDIAN'S SIGNATURE
FOR PRESCRIBED MEDICATIONS AND DAILY OVER-THE-COUNTER MEDICATION

Camper's Name: Last _____ First _____ Middle _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY YOUTH CAMP PERSONNEL

If a Youth Camp chooses to administer medications, the Connecticut State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse, first aid, the director, alternate director or youth camp counselor to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, physician's or dentist's name and date of the original prescription. Daily Over the counter medication must also be in the original container.

OVER-THE-COUNTER MEDICATIONS NOT LISTED ON FORM G ALSO REQUIRE A PHYSICIAN'S WRITTEN ORDER AND MUST BE IN THEIR ORIGINAL CONTAINERS.

MEDICATIONS CURRENTLY BEING TAKEN (Meds brought to camp must be in their original labeled pharmacy container.)

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #4 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

ATTACH ADDITIONAL PAGES FOR MORE MEDICATIONS.

Identify any medications taken during the school year that participant does/may not take during the summer:

AUTHORIZATION FOR LICENSED MEDICAL PERSONNEL (PHYSICIAN OR DENTIST)

The person named herein may be administered the medications indicated above. In the event the camp nurse is unavailable, camper/staff member (check one) _____ may _____ may not self-administer this medication under the supervision of camp first aid personnel.

Signature _____ Title _____

Physician or Dentist Signature

Printed _____ License # _____

Address _____ City/State/Zip _____

Telephone # _____ Date _____

AUTHORIZATION FOR PARENT/GUARDIAN

I hereby authorize the camp nurse to administer the medications indicated above as ordered by my physician and the camp physician. In the event the camp nurse is unavailable, camper/staff member (check one) _____ may _____ may not self-administer this medication under the supervision of camp first aid personnel.

Signature _____ Relationship to Child _____

Printed Name _____ Date _____

Parent/Guardian Signature

- ☐ Camper
☐ Staff

FORM F – RETURN WITH FORMS A, B, C, D, E

MEDICAL EVALUATION
MUST BE GOOD WITHIN 2 YEAR OF CAMPER'S LAST DAY AT CAMP

SCHOOL PHYSICAL AND SPORTS PHYSICALS ALSO ACCEPTED

MEDICAL PRACTITIONER MUST COMPLETE AND SIGN

Name _____ Date of Birth _____
Guardian _____ Address _____
Home Phone () _____ Work Phone () _____ Cell Phone () _____
Emergency Contact #1 _____ Home Phone () _____ Cell Phone () _____
Emergency Contact #2 _____ Home Phone () _____ Cell Phone () _____
Date of Arrival at Camp: _____ Departure Date: _____

Date of Exam _____

_____ May participate in all camp activities.

_____ May participate except for: _____

Medical information pertinent to routine care and emergencies: _____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunizations Practices:

(If you require a religious exemption for immunizations please contact our office at 860-974-1122)

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus			TB Test		Result:

Comments: _____

Health History: (Check all that apply)

_____ Epilepsy or seizures _____ Frequent ear infections _____ Menstrual problems _____ Asthma
_____ Frequent sore throats _____ Headaches _____ Bed wetting _____ Heart Disease
_____ Back pain or strain _____ Alcohol/drug addiction _____ Diabetes _____ Eye Glasses
_____ Heart Disease OTHER: _____

Pertinent past medical treatment: _____

ALLERGIES

Medication Allergies

Describe reaction and management of reaction

Food Allergies

Other Allergies (including: insect stings, hay fever, asthma, animal dander, etc.)

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

_____, M.D. Telephone: () _____ Date: _____

Examining Physician Signature

RETURN TO: WINDHAM-TOLLAND 4-H CAMP, 326 TAFT POND ROAD, POMFRET CENTER, CT 06259
Fax (860) 974-3327

FORM G – OVER-THE-COUNTER MEDICATIONS
Return with Forms A, B, C, D, E, F

THIS FORM REQUIRES PARENT/GUARDIAN'S SIGNATURE
TO AUTHORIZE THE ADMINISTRATION
OF ANY OVER-THE-COUNTER MEDICATIONS

Camper's Name: Last _____ First _____

I DO WISH OVER-THE-COUNTER MEDICATIONS TO BE GIVEN TO MY CHILD.

I understand the Health Care Provider will administer the following over-the-counter medication or the generic version, if necessary, according to directions on the bottles unless a physician directs otherwise. The Camp provides these as needed over-the-counter medications. **(Please cross out any medication on this list you do not want your child to receive.)**

Symptom:

Athletes Feet
Skin irritations
Minor aches/pain/fever
Minor cough/sore throat

Minor Allergic Reactions/Allergies
Poison Ivy/Rashes
Bug Bites

Indigestion/Heartburn
Constipation
Clogged Ears
Open Areas/Cuts
Lactose Intolerant
Sore Muscles

Over-The-Counter Medication:

Desenex or similar powder/spray
Gold Bond Powder
Tylenol/Advil/Ibuprofen/Aleve
Robitussin/Cough/Throat Drops/Chloraseptic
Throat Spray
Benadryl, Claritin, Xyzel and Zyrtec
Calagel Lotion/Calamine Lotion
Benzocaine Swabs/Dermoplast
Hydrocortisone Cream/Benadryl Cream
Antacid/Pepto Bismol/Tums
Milk of Magnesia
Auro-Dry
Bacitracin/Triple Antibiotic ointment
Lactaid tablets
Bengay (Menthol Muscle Pain relieving cream)

If any medication is not listed above, and taken daily you must use Form E obtain a doctor's signature in order for the Camp Nurse to give said medication to your camper.

Date: _____

Signature of Parent or Legal Guardian

Print Parent or Legal Guardian's Name _____

Parent's Home Phone () _____ Work Phone () _____ Cell Phone () _____

=====

I DO NOT WISH ANY MEDICATIONS TO BE GIVEN TO MY CHILD, _____
Camper's Full Name

Date: _____

Signature of Parent or Legal Guardian

Print Name of Parent or Legal Guardian _____

Parent's Home Phone () _____ Work Phone () _____ Cell Phone () _____