

**REGISTER ONLINE AT www.4hcampct.org
CAMP APPLICATION - 2026 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., 2025 _____
 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 2:00pm-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 2:00 PM – 4 PM thru Fri 7 PM Mon thru Fri - 8-8:30 AM – 5-5:30 PM Sun. 2:00pm 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)					
Circle your week choice(s):							
WEEK 1 –Winter Olympics Wk <i>June 21 – June 26</i>	RES \$650	DAY \$420	CLOVER A 6/21 - 6/23 Sun - Tues \$350	CLOVER B 6/24 – 6/26 Wed - Fri \$350	COW CAMP \$25	(9+ Yrs Old) Wood Fiber Crafts \$40	(9+ Yrs Old) Riding + \$290
WEEK 2 – Decades Wk <i>June 28 – July 3</i>	RES \$650	DAY \$420	CLOVER C 6/28 – 6/30 Sun – Tues \$330	CLOVER D 7/1 – 7/3 Wed – Fri \$330		Wood Fiber Crafts \$40	Riding + \$290
WEEK 3 – Carnival Wk <i>July 5 - July 10</i>	RES \$650	DAY \$420	CLOVER E 7/5 – 7/7 Sun – Tues \$350	CLOVER F 7/8 – 7/10 Wed - Fri \$350		Wood Fiber Crafts \$40	Riding + \$290
WEEK 4 – Zoo Wk <i>July 12 - July 17</i>	RES \$650	DAY \$420	CLOVER G 7/12 – 7/14 Sun - Tues \$350	CLOVER H 7/15– 7/17 Wed- Fri \$350		Wood Fiber Crafts \$40	Riding + \$290
WEEK 5 – Pirates & Vikings Wk <i>July 19 - July 24</i>	RES \$650	DAY \$420	Clovers I \$650			Wood Fiber Crafts \$40	Riding + \$290
WEEK 6 – International Wk <i>July 26 – July 31</i>	RES \$650	DAY \$420	Clovers J \$650			Wood Fiber Crafts \$40	Riding + \$290
WEEK 7– Puddles & Bubbles Wk <i>August 2 - August 7</i>	RES \$650	DAY \$420	Clovers K \$650			Wood Fiber Crafts \$40	Riding + \$290
WEEK 8 – Capture the Flag Wk <i>August 10 – August 14</i>	DAY CAMP ONLY \$420						

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, 2026.** 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 _____

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

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

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

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 out of camp trips, 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: _____

(ie: Seasonal, medications, animals, etc)

The plan of care is ___ Avoidance

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

___ Other, please specify _____

___ Are there any conditions your child receives treatment or medication for, that they will need while at camp?

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

___ Does your child have any special dietary needs: (Religious, preference)? _____

___ Does your child have any oral or dental needs? _____

___ Is your child hearing impaired? ___ Yes ___ No. If yes what is the plan of care: _____

___ Is your child vision impaired? ___ Yes ___ No ___ Glasses ___ Contacts ___ Other

The plan of care is _____

___ My child has a chronic illness or diagnosis of: _____

The plan of care is _____

___ Does your child have cognitive, emotional, or psychological limitations? Do they have a diagnosis ___ Yes ___ No

If a diagnosis, please list here: _____

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

___ Does your child have social limitations? ___ Yes ___ No

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

___ Have your child had a serious illness, hospitalization or accident in the last 12 months. ___ Yes ___ No

Please explain. _____

___ Has your child required psychiatric counseling/hospitalization? ___ Yes ___ No _____

___ Does your child have physical limitations as ordered by their Physician? ___ Yes ___ No (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 and what you would like to discuss _____ -

___ Does your child require a plan of care for any special health needs? ___ Yes ___ No

(If you answered yes to any of the questions above please check yes)

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- Please include immunization record

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: **Please attach a copy Camper's immunization record.**

(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)

For any medication/ supplements not listed above, and to be taken daily while at camp, you must use Form E with a doctor's signature in order for the Camp Nurse to give said medication/ supplements 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 () _____

Windham- Tolland 4-H Camp Refund, Transfer and Credit Policy

Windham-Tolland 4-H Camp is outstanding because of the staff and quality programming we provide.

Our refund policy allows us to reliably staff our programs with highly trained staff to help your children grow in all areas of life. Note: Camp refund, transfer or credit requests must be made in writing to registrar@4hcampct.org.

- ***Refund: Receiving check or credit card reimbursement for programs paid for by payee.***
- ***Transfer: Moving camper tuition monies within Windham-Tolland 4-H Camp registration system to a different week of camp for the same child in the same camp season.***
- ***Credit: Releasing camper tuition monies and applying it to the family's general account for use by another sibling (not to be turned into cash, check or credit reimbursement), credit expires after 2 years from date of request. CREDIT IS FOR USE BETWEEN IMMEDIATE FAMILY MEMBERS ONLY.***
- ***We will do our best to honor all transfer & Credit requests but cannot guarantee space availability due to the first-come, first-served nature of our program.***

Refund, Transfer and Credit Policy

Email Received	Credit Card/ Check Refund	Transfer Camp Weeks	Credit
Prior to May 1	Day Camp/Short Clover Sessions: Available, less \$50 processing fee per camper week Resident Camp/Teen Leader: Available, less \$100 processing fee per camper week Riding: Available less, \$50	Available	Available
May 1- May 20	Day Camp/Short Clover Sessions: Available, less \$100 processing fee per week/per child Resident Camp/Teen Leader: Available, less \$200 processing fee per camper week Riding: Available less, \$50	Available	Available
May 21- June 6	Not Available after May 20 th .	Available	Available
June 6-End of camp	Not Available after May 20 th .	Available as long as there is availability	Not Available

In the event camp is cancelled

We reserve the right to cancel programs at any time for the health and safety of campers, staff and families. If such cancellations do occur the following refund/transfer/ credit policy will be implemented. We will provide refunds less a \$20 per week administrative fee. (Maximum per Family fee is \$100) or funds maybe transferred to another session or activity.

Please know that many costs are incurred before your child arrives at camp, please know that these policies are in place so that we can continue to provide quality programs for years to come.

I have received and read this copy of the refund policy.

Signature of Parent or Legal Guardian

Date