



## 2019 Vacation Camps

### Registration Form

*Payment and forms due before first day of camp*

Camper Name _____		Grade _____	Age _____	Gender M or F
Street _____		City _____	State _____	Zip _____
Parent(s)/ Gaurdian(s) _____ / _____		Emergency Contact _____ (Other than legal guardian)		
(Cell #) _____	(Other #) _____	(Cell #) _____	(Other #) _____	
(Main contact's Email) _____				

[Click this link to create an account and register online.](#) Please note forms still need to be completed and sent in to 80 Carby Street, Westwood, MA 02090

<b>FEB</b>	<p><b>\$80 per day or \$280 for all four days of February Vacation program</b></p> <p>○ - Tue., Feb. 19    ○ - Wed., Feb. 20    ○ - Thu., Feb. 21    ○ - Fri., Feb. 22</p>
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<b>APR</b>	<p><b>\$80 per day or \$280 for all four days of April Vacation program</b></p> <p>○ - Tue., Apr. 16    ○ - Wed., Apr. 17    ○ - Thu., Apr. 18    ○ - Fri., Apr. 19</p>
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#### Extended Day

*If you plan to use morning extended day, you MUST sign up in advance (we staff based on enrollment). If you do not sign up for afternoon extended day, we charge for the hour starting at 3:10 and 4:10 PM.*

Extended Day is available 8 - 9 AM and 3 - 5 PM. Please circle days and times and add \$10 per hour to total amount below.

- |                                      |                                      |  |
|--------------------------------------|--------------------------------------|--|
| <b>Tue:</b> 8-9 AM / 3-4 PM / 3-5 PM | <input type="radio"/> - Feb Vacation | <input type="radio"/> - April Vacation |
| <b>Wed:</b> 8-9 AM / 3-4 PM / 3-5 PM | <input type="radio"/> - Feb Vacation | <input type="radio"/> - April Vacation |
| <b>Thu:</b> 8-9 AM / 3-4 PM / 3-5 PM | <input type="radio"/> - Feb Vacation | <input type="radio"/> - April Vacation |
| <b>Fri:</b> 8-9 AM / 3-4 PM / 3-5 PM | <input type="radio"/> - Feb Vacation | <input type="radio"/> - April Vacation |

**TOTAL AMOUNT DUE:** \$ \_\_\_\_\_ Please make checks payable to Hale Reservation or call 781-326-1770 to pay by credit card.

**Photos:** I hereby grant Hale Reservation permission for my child's photo to appear in videos, newspapers, brochures, on websites or other promotional literature.

**Authorization for Treatment:** In case of health problem or emergency, I authorize Hale Reservation, Inc. to administer first aid and, where necessary, to transport my child to Norwood Caritas Hospital Emergency Room, and to order X-rays, routine tests and treatment; and to release any records necessary for insurance purposes. In the event I cannot be reached in an emergency.

**Acknowledgement of Risk & Waiver:** I understand and acknowledge that my participation in the above listed program may involve a variety of activities including; indoor and outdoor games, sports, rope courses, and other rigorous physical activities. I hereby release and discharge, and agree to indemnify and hold harmless, Hale Reservation and its officers, directors, members, agents, employees, volunteers and any other persons or entities acting on its behalf, against all claims, demands, and causes of action whatsoever, either in law or equity, relating to or arising from any medical treatment, recommendation, transportation or admin-istration, or any lack thereof.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

*Hale is not affiliated with any public school system.*



Vacation Camp
2019 Health History, Emergency
Contact, and Release Form

HALE RESERVATION, 80 CARBY STREET

781-326-1770

781-326-0676

WWW.HALERESERVATION.ORG

Last Name: [grid] Middle Initial: [grid]

First Name: [grid] Birth Date (MMDDYY): [grid]

Street City/Town State Zip

Male (circle one) Female Identifying Marks: \_\_\_\_\_

Parent or Guardian Information

Parent or Guardian Address Phone Work Cell Phone Email (repeated for two guardians)

Please list at least one emergency contact that, if necessary, could provide transportation home.

Emergency Contact Cell Phone Work (repeated for two contacts)

Allergies

Insect Bite Bee Sting Food Seasonal Medications Other Yes/No Reaction Severity (circle one)

Please explain/specify any of the above that were answered "Yes" (i.e. type of food allergy, medication associated, etc.)

If medications will be administered at camp for above allergies a "Medication Information Form" must be completed

Physician Information

Name of family physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Information

Insurance Carrier: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_ Policy/ Group #: \_\_\_\_\_

Immunization History: Massachusetts requires a Certificate of Immunization for all campers and staff. You may use the form provided or a copy from your doctor's office. Check if attached [checkbox]

**Relevant Past Medical History, General Information, and Restrictions**

Does your child (or staff member) have Asthma? **Yes (circle one) No**

\*Will your child (or staff member) be bringing an inhaler to camp? **Yes (circle one) No**

Are there any physical, mental, or psychological conditions requiring medication, treatment, or restrictions while at camp?

\*Does your child or (staff member) take any prescription or over-the-counter medication at home? **Yes (circle one) No**

Please list any past medical treatment or recent injuries: \_\_\_\_\_

Describe any specific activities from which your child (or staff member) should be exempted: \_\_\_\_\_

Any dietary modifications or restrictions? **Yes (circle one) No** Please explain: \_\_\_\_\_

Does your child have an IEP or 504 plan? **Yes (circle one) No**

Are there any accommodations or services that we can provide to make the summer as successful as possible? \_\_\_\_\_

Please share any information that would help Summer Staff best serve your child: \_\_\_\_\_

**\*If "Yes" a "Medication Information Form" must be completed**

**Authorizations:**

Accuracy of Information: This health history is correct so far as I know and the person herein described has permission to engage in all camp activities except as noted.

Photo Release: I authorize Hale, and American Camp Association to have my child's (or staff members) photo to appear in camp brochures, videos, on websites or other promotional literature.

Authorization for Treatment: In case of an emergency, I authorize Hale Reservation to administer first aid and to transport my child or (staff member) to the nearest hospital emergency room and to order X-rays; routine tests and treatment; and to release any records necessary for insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director, or his/her designee, to secure and administer treatment, including hospitalization, for the person named above. This form can be photocopied for camp trips.

Authorization for Medications: I authorize the Hale Health Staff and its designees to administer the following medications (on an "as needed" basis unless contraindicated): Acetaminophen (Tylenol), Ibuprofen (Motrin/Advil), Antacid (Tums), Diphenhydramine HCl (Benadryl), and Anti-Itch Creams.

Acknowledgment of Risk and Waiver: I understand and acknowledge my camper (or staff member) may participate in a variety of activities including; swimming, boating, outdoor games, sports, rope course, and other rigorous physical activities. I hereby release and discharge, and agree to indemnify and hold harmless Hale Reservation and its officers, directors, members, agents, employees, volunteers, and any other persons or entities on its behalf, against all claims, demands, and causes of actions whatsoever, either in law or equity, relating to or arising from any participation, medical treatment, recommendation, transportation or administration, or any lack thereof.

**Signature of Parent/Guardian of Camper, Staff Member, or Parent/Guardian of Staff Member under 18 years of Age**

Signature \_\_\_\_\_

Date \_\_\_\_\_



**Authorization to Administer Medication to a Camper**  
 (completed by parent/guardian)

<b>Camper and Parent/Guardian Information</b>	
Camper's Name:	
Age:	Food/Drug Allergies:
Diagnosis (at parent/guardian discretion):	
Parent/Guardian's Name:	
Home Phone:	Business Phone:
Emergency Telephone:	
<b>Licensed Prescriber Information</b>	
Name of Licensed Prescriber:	
Business Phone:	Emergency Phone:
<b>Medication Information 1</b>	
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 \_\_\_\_\_ (name of camp) to administer, to my child, \_\_\_\_\_ (name of camper) the 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:
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\*\* **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.