BOYS & GIRLS CLUB
OF MILFORD

Summer Camp 2019

All forms and a deposit **must** be received before your child's membership for the Summer Camp is secure. There are no exceptions.

- Online Registration
  ___Week #1: 7/01/19 - 7/05/19, closed 07/04/19
  ___Week #2: 7/08/19 - 7/12/19
  ___Week #3: 7/15/19 - 7/19/19
  ___Week #4: 7/22/19 - 7/26/19
  ___Week #5: 7/29/19 - 8/02/19
  ___Week #6: 8/05/19 - 8/09/19
  ___All 6 Weeks

- Membership Disclaimer
- Household Certification Form (CDBG)
- Recent Physical Form
- Copy of Birth Certificate
  (New enrolling 5yr. old, must have completed Kindergarten)
- Payment $ _____
- Payment $ _____
  (Camp must be paid in full by Monday - June 3, 2019)

Optional:

- Care 4 kid's approval/denial letter
- BGCM Scholarship form **(deadline is Monday - April 1st)**

Member Name: _____
Date Complete: _____

BOYS & GIRLS CLUB
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Membership Disclaimer

Summer Camp 2019

I have reviewed the completed application and acknowledge that the information provided is true and accurate to the best of my knowledge.

I also acknowledge that I have read the Parent Handbook, understand the rules contained in the Parent Handbook and explained the Rules to my child. I request that my child be admitted into membership of the Boys & Girls Club of Milford and I give permission for my child to participate in all club activities.

I further acknowledge that the failure by me or my child to follow the rules may result in my child's suspension or expulsion from the Club. I agree that the Club will not be responsible for any accident to my child on the Club's premises or while engaged in any of its activities.

If I agree that photos of my child may be used in public relations materials, I give my consent for any photographs in which my child may appear to be used in any way the Club may choose to use them for that purpose.

☐ **Yes, I give my child permission to be used in public relations material.**

☐ **No, I do not give my child permission to be used in public relations material.**

I acknowledge that the Boys & Girls Club of Milford is not a peanut free facility and some snacks/food may contain nuts.

If you would like to opt out of the Snack Program please check this box. ☐

_____

Parent Signature Date

_____

Member Signature Date

Household Certification Form

Participant Name: [ ] Male [ ] Female
Address
Number of Person(s) in the Household: [ ] Number of Children under the Age of 18: [ ] Female Headed Household Yes ____ No _____
Number of Persons 62 years of Age or Older: [ ] Household with Disabled Person: [ ]
Student Status: Name_____ F/T__ or P/T __ Age: Name_____ F/T__ or P/T __ Age:

Please Provide Household Race/Ethnicity (*Check one per household).*

[ ] White
[ ] Black
[ ] Asian/Pacific Islander
[ ] American Indian/Alaskan Native
[ ] Asian White
[ ] Black/African American & White
[ ] Other Multi-Racial
[ ] Hispanic
[ ] Hispanic, White
[ ] Hispanic, Black
[ ] American Indian/Alaskan Native & Black/African American
[ ] Asian/Pacific Islander
[ ] Native Hawaiian/Other Pacific Islander

Household Income

The program participant checks the income level that meets, but does not exceed, the total household adjusted gross income (AGI). A household income includes persons related, and unrelated, over the age of 18 and living in the home for 6 months or more. The program manager may request additional income documentation when required.

Total Household Income (Check one box)	**Household Income Level (AGI)**
	$47,600
	$54,400
	$61,200
	$68,000
	$73,450
	$78,900
	$84,350
	$89,800

CERTIFICATION:

I/We hereby certify that the information on this form is complete and correct to the best of my knowledge.

Participant Signature _____ Date _____

Participant Signature _____ Date _____

This information is required to receive Federal funds to assist this organization to continue to offer this program or activity. The information on this form is confidential and will not be shared with an agency other than the Grantor, the Department of Community Development, which regulates use of Community Development Block Grant funds for the City of Milford. This information is used to determine program eligibility and the statistical information of the participant to ensure that CDBG funds assist low and moderate-income individuals and families.

SAMPLE FORM

YOUTH CAMP HEALTH EXAM/RECORD FOR CAMPERS AND STAFF

Physical Exams Are Valid For 3 Years From Date of Last Examination

☐ Camper
☐ Staff

Please Return Completed Form to the Camp

Name_____ Date of Birth_____ Phone_____

Guardian_____ Address_____

Emergency Contact_____ Telephone_____

Date of Arrival at Camp: _____ Departure Date: _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Date of Exam ____/____/____

May participate in all camp activities ☐ YES ☐ NO

May participate except for: _____

Does the individual have any known medical or emotional illness or disorder that poses a risk to other children or which affects the individual's functional ability to participate safely in a youth camp? ☐ YES ☐ NO

If yes, please explain _____

_____

Are there any prescription or over the counter medication(s) this individual needs to take while at camp? ☐ YES ☐ NO

If yes, indicate names of medication(s):_____

NOTE: A written authorization and parent permission for the administration of medication at camp are required.

Does the individual have any disabilities or special health care needs such as allergies, special dietary needs? ☐ YES ☐ NO

If yes, please explain _____

_____

NOTE: If the camper has a special health care need or disability that requires special care be taken or provided during the time the individual is at camp, an individual plan of care shall be developed with the parent and health care provider and updated as necessary. The plan shall include appropriate care of the camper in the event of a medical or other emergency and signed by the parent and staff responsible for the care of the camper.

If camper/staff is school aged or younger, have they been immunized in accordance with the schedule adopted by the Commissioner of Public Health pursuant to section 19a-7f of the Connecticut General Statutes? ☐ YES ☐ NO

Additional Comments:

_____

_____

Printed Name of Health Care Provider: _____

Address: _____ Phone: _____

Signature of Physician, PA, APRN or RN _____ Date Form Signed: _____

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Care Centers and Group Care Homes, licensed Family Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth___/___/___ Today's Date___/___/___

Address of Child/Student _____ Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____ Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/_____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (_____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date ____/____/____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _____
Signature Date

****

Today's Date _____Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink or electronic) _____

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

Medication Administration Record (MAR)

Name of Child/Student_____ **Date of Birth** _____/_____/_____

Pharmacy Name _____ **Prescription Number** _____

Medication Order_____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ **Authorization form is complete**

☐ **Medication is appropriately labeled**

☐ **Medication is in original container**

☐ **Date on label is current**

Person Accepting Medication (print name) _____ **Date** ____/____/____