



**BOYS & GIRLS CLUB
OF MILFORD**

Summer Camp 2021

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

Registration:

- ☐ Online Registration Complete
 - ___ Week 1: June 28, 2021 – July 2, 2021
 - ___ Week 2: July 5, 2021 – July 9, 2021
 - ___ Week 3: July 12, 2021 – July 16, 2021
 - ___ Week 4: July 19, 2021 – July 23, 2021
 - ___ Week 5: July 26, 2021 – July 30, 2021
 - ___ Week 6: August 2, 2021 – August 6, 2021
 - ___ Week 7: August 9, 2021 – August 13, 2021
 - ___ Week 8: August 16, 2021 – August 20, 2021
 - ___ All 8 Weeks: June 28, 2021 – August 20, 2021

Paperwork:

- ☐ Membership Disclaimer
- ☐ Household Certification Form (CDBG)
- ☐ Informed Consent Waiver
- ☐ BGCM Assumption of Risk Waiver
- ☐ Additional Pick-Up Form
- ☐ Pre – Camp Health Screening – **Due First day of Camp**
- ☐ Most Recent Physical Form
- ☐ Authorization of Administration of Medication Form, if applicable
- ☐ Individual Plan of Care Form, if applicable
- ☐ Copy of Birth Certificate (for new enrolling 5yr. old's, must have completed Kindergarten)
- ☐ Permission to Leave Form, if applicable (Only for Middle/High School Members)

Payment:

- ☐ Care \$ Kid's Approval/Denial Letter, if applicable
- ☐ BGCM Scholarship Form, if applicable (deadline is April 1st)
- ☐ Payments Made: \$ _____ Date: _____ \$ _____ Date: _____
- ☐ Paid in Full

***Camp must be paid in full, 24 hours after Registration Confirmation Email. *Contact us if you need a payment plan.**

Member Name: _____ Date Complete: _____



Membership Disclaimer

Summer Camp 2021

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 Summer Camp 2021 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's 2021 Summer Camp Program 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 may contain nuts.

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

Parent 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).

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> White
<input type="checkbox"/> Black
<input type="checkbox"/> Asian/Pacific Islander
<input type="checkbox"/> American Indian/Alaskan Native
<input type="checkbox"/> Asian White
<input type="checkbox"/> Black/African American & White
<input type="checkbox"/> Other Multi-Racial | <input type="checkbox"/> Hispanic
<input type="checkbox"/> Hispanic, White
<input type="checkbox"/> Hispanic, Black
<input type="checkbox"/> American Indian/Alaskan Native & Black/African American
<input type="checkbox"/> Asian/Pacific Islander
<input type="checkbox"/> Native Hawaiian/Other Pacific Islander |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Please Type Household Race/Ethnicity here: _____

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.

INFORMED CONSENT

(this form may be used for staff and parents of children enrolled at a youth camp during the COVID-19 declared emergency)

I hereby attest that I have been informed of the following pertaining to the coronavirus:

People who are 65 years and older and people of any age who have serious underlying medical conditions or are at higher risk for severe illness from COVID-19 are recommended to stay at home. A list of medical conditions associated with a higher risk for severe illness from COVID-19 can be found in [CDC's guidance](#).¹ Individuals and families should consult their healthcare provider to determine whether they have medical conditions that place them at risk.

- Staff and children living in households with individuals who are 65 years and older OR have higher risk for severe illness from COVID-19 are recommended to stay home.

Signature of Staff or Parent/Guardian

Printed Name

Child's Name (if a parent/guardian)

Date

¹ Includes chronic lung disease or moderate to severe asthma, serious heart conditions, immunocompromised (cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications), severe obesity (body mass index [BMI] of 40 or higher), diabetes, chronic kidney disease undergoing dialysis and liver disease. Individuals should consult their healthcare provide to determine whether they have medical conditions that place them at increased risk for severe illness from COVID-19.



**BOYS & GIRLS CLUBS
OF MILFORD**

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Boys & Girls Club of Milford has put in place preventative measures to reduce the spread of COVID-19; however, we **cannot guarantee** that you or your child(ren) will not become infected with COVID-19. Further, **attending Boys & Girls Club of Milford Summer Camp 2021 could increase** your risk and your child(ren)'s risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by COVID-19 by attending **Boys & Girls Club of Milford Summer Camp 2021** and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at **Boys & Girls Club of Milford Summer Camp 2021** may result from the actions, omissions, or negligence of myself and others, including, but not limited to, employees, volunteers, and program participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s attendance at **Boys & Girls Club of Milford Summer Camp 2021** or participation **Boys & Girls Club of Milford Summer Camp 2021**. On my behalf, and on behalf of my child(ren), I hereby release, covenant not to sue, discharge, and hold harmless **Boys & Girls Club of Milford**, its employees, Board of Directors, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of **Boys & Girls Club of Milford**, its employees, Board of Directors, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in **Boys & Girls Club of Milford Summer Camp 2021**.

Signature of Parent/Guardian

Date

Name of Parent/Guardian

Name of Camp Participant(s)



PICK-UP LIST

Child's Name: _____

Please add the following names to my child's pick-up list:

First / Last Name

Phone

Relationship to Member

I give permission for my child to be picked up by those names listed above. If there are any changes to this list, I will be sure to inform The Boys & Girls Club of Milford.

Print Name

Signature

Date

Camper Name: _____

Session: _____

Pre-Camp Health Screening

Dear Camp families,

In an effort to minimize illness at camp we ask that you check on the health of your camper daily beginning 14 days prior to camp. The best camp sessions start with healthy campers and this begins at home. Please bring this completed form to camp on opening day.

Please indicate if your camper has any of the following symptoms prior to camp and record a temperature daily. If any temperature or symptoms are present, please have your camper evaluated by a licensed provider and contact camp for further guidance.

Symptoms (symp):

- Cough
- Shortness of breath or difficulty breathing
- Fever
- Chills
- Muscle Pain
- Sore throat
- New loss of taste or smell
- Nausea
- Vomiting
- Diarrhea

Please initial

1. My child has not been around anyone with any of the listed symptoms or diagnosis of COVID19 in the 14 days before the start of camp. Initial _____

2. No one in our household has been sick in the 14 days prior to camp. Initial _____

3. My child has not traveled by air or traveled out of state in the 14 days prior to camp. Initial _____

4. My child has adhered to our state's guidelines regarding COVID19. Initial _____

Start date of
temperature/
symptom
screening:

Day:	14	13	12	11	10	9	8
Temp/ symp							
Day:	7	6	5	4	3	2	1
Temp/ symp							

Our signature indicates that we completed this health screening daily for 14 days prior to camp and to the best of our ability. We understand that arriving to camp healthy is vital to a healthy camp for all campers.

Parent Signature: _____ Date: _____

Camper Signature: _____ Date: _____

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
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> 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 ____/____/____

Individual Plan of Care for a Child
With Special Health Care Needs or Disabilities

Child's Name: _____ Date of Birth ____/____/____

Special health care need or disability:

Plan for appropriate care of the child in a medical emergency. An individual Plan of Care is necessary when a child has a special health care need or disability and it is necessary that special care be taken or provided while the child is at the youth camp.

Other relevant information: (e.g. precautions to be taken to prevent a medical or other emergency)

Signature(s) of the Parent(s):

Date Signed:

____/____/____
____/____/____

NOTE: Section 428-3(a) requires a child's health record to include information regarding disabilities or special health care needs such as allergies, special dietary needs, dental problems, hearing or visual impairments, chronic illness, developmental variations or history of contagious disease, and an individual plan of care for the child with special health care needs or disabilities. The plan shall be developed with the child's parent(s) and health care provider and updated as necessary. Such plan of care shall include appropriate care of the camper in the event of a medical or other emergency and shall be signed by the parent(s) and staff responsible for the care of the camper.

Please use the reverse side of this form for signature(s) of all staff responsible for the care of this child.



PERMISSION FORM

Leave the Building

I give my child _____ permission to

leave the Boys & Girls Club of Milford once they have signed into the club. Once members leave the building they will be considered signed out for the day and will not be able to re-enter unless they are accompanied by their parent/guardian. I understand that the Boys & Girls Club of Milford is not responsible for my child while they are outside the building without supervision.

Signature of Parent

Date

Phone number I can be reached at _____