Grange Camp
40 Parkwood St.
Apt B1
Albany NY, 12208

Grange Camp 2015
Camp Aldersgate
7955 Brantingham Rd, Greig, NY 13345
July 19th - July 24th, 2015
Ages: 7 to 18 years old
Cost: $225 per Camper

Please send in <u>Registration and Health forms</u> with a non-refundable $5O.OO Deposit postmarked by June 1st to: Grange Camp, 40 Parkwood St, Apt B1, Albany NY 12208. (Please NO PERSONAL Checks)

There is a $25 discount available to Grange members who have the entire application and health form completed and mailed in by April 1st.

Camp will start on Sunday July 19th with check in between 1:00 & 3:00 PM, and check out is Friday July 24th at 10:00AM. Please call ahead if you cannot meet these scheduled times. If someone other than a parent is picking up a camper, a permission slip must be sent with the registration form.

If you have any questions please contact: Matthew Shoop at (518)522-9202 or email camp@nysgrange.org

New York State Grange Camper Registration Form (Duplicate if necessary)

Name:_____

Sex: M F Age: _____ DOB: _____

If over age 16, would you like to be a CIT? Yes No

Name of Parent: _____

Address

_____

_____

_____

Home Phone: _____

Cell Phone: _____

Email: _____

Emergency Contact Person & Phone: _____

Grange: _____

Have you attended Grange Camp before? Yes No

Did a Grange help send you to Camp? Yes No

if Yes, who? _____

Please send in Registration and Health forms with a non-refundable $50.00 Deposit postmarked by June 1st to:

Grange Camp, 40 Parkwood st, Apt B1, Albany NY, 12208. (Please NO PERSONAL Checks, checks from your Grange are fine.)

Parent's Signature: _____

Pack your Bags!

label everything and pack it all in an easy-to-carry bag or suitcase. Occasionally campers will leave belongings behind after they leave camp. Having your things labeled helps to see that the items get back to you. We reserve the right to inspect any belongings on camp property.

PLEASE BRING:

Shoes	**Boots**
Underwear	**Shirts**
Sweatshirt/Sweater	**Raincoat/Poncho**
Bathing Suit	**Long Pants**
Socks	**Pajamas**
Water shoes	**Water bottle**
Comb/Brush	**Toothbrush and toothpaste**
Pillow	**Fitted sheets for twin bed or Sleeping bag**
Towels	**Sunscreen**
Shampoo	**Writing Paper & Paper**
Disposable Camera (optional)	**Insect Repellent**
Flashlight with extra bulb and batteries	

PLEASE DO NOT BRING:

Cell Phones	**Radios**	**Spray cans**	**Money**
Candles/Lanterns	**Food, Candy, or Gum**	**Walkman/iPods**	**Expensive Cameras**
Weapons of any kind	**Handheld video games**	**Knives/Jack knives**	**Jewelry**

EVERYDA Y WEAR AT CAMP:

Socks and shoes ARE a must at ALL times during camp. Campers need to apply sunscreen every day. Campers should use bug spray in the evenings or on hikes. Use discretion when choosing camp clothes. Modest clothing should be worn at ALL times. Inappropriate language or graphics on clothing is NOT acceptable. Please remember that the camp experience can often be very hard on clothes. We suggest that you do not bring new clothing or shoes, because they can easily be damaged during a week at camp. CAMP IS NOT RESPONSIBLE FOR LOST, STOLEN, OR DAMAGED ITEMS.

Please feel free to write your camper one or more times during the week of camp. The campers enjoy hearing from Home.

Health Form

The health form is kept confidential and used by our health services staff (or emergency medical personnel). **Every camper needs a completed health form to participate in any summer camp programs. Please fill out this form as completely as possible.** Thank you!

Basic Contact Information

Camper
Name_____
Birth date_____/_____/_____ Age _____ Gender Male Female
Home
Address_____
STREET CITY STATE ZIP
Home Phone_____
Parent/Guardian #1
Name_____
Relationship:_____
Day Phone_____ Night Phone_____
Day Phone is Home Work Cell Night Phone is Home Work Cell
Parent/Guardian #2
Name_____
Relationship:_____
Day Phone_____ Night Phone_____
Day Phone is Home Work Cell Night Phone is Home Work Cell
Additional Emergency Contact_____ Relationship_____
(In case we can't reach YOU)
Day Phone_____ Night Phone_____
Day Phone is Home Work Cell Night Phone is Home Work Cell
Family Physician Name_____ Phone_____
Dentist/Orthodontist Name_____ Phone_____

Insurance Information

Is the camper covered by family medical/hospital insurance? Yes No
If yes, indicate Insurance Carrier_____
Group #_____ Policy #_____
Policy Holder's Name_____
Relationship to participant_____

Allergies

☐ Camper does not have any Allergies
Camper is allergic to and has reactions of:
_____

Immunizations

Please record the month and year of immunizations.

DPT (Diphtheria, Pertussis, Tetanus)..... _____ HIB (Haemophilus Influenza B)..... _____
Tetanus Booster ..... _____ Tuberculin Test ..... _____
Polio..... _____ Varicella (Chicken Pox)..... _____
MMR (Measles, Mumps, Rubella)..... _____ Hepatitis B ..... _____

MEDICATIONS

Will camper be taking medications while at camp? Yes No *(Medications include prescription, over-the-counter, vitamins, inhalers, etc.)*

If camper will be taking medications while at camp, it is state law to secure your consent for medication distribution and for the use of medical devices. The medication must be administered by Health Services Staff. Please list all (prescription and non-prescription). Include the medication name, prescribing physician, physicians' phone number, and the dosage instructions. Use an additional sheet if needed. When you check-in at camp, please provide all medications (in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.)

Medication_____ Dosage_____
Take at what times_____
Reason for Taking_____
Prescribing Physician_____
Phone_____
Medication_____ Dosage_____
Take at what times_____
Reason for Taking_____
Prescribing Physician_____
Phone_____
Medication_____ Dosage_____
Take at what times_____
Reason for Taking_____
Prescribing Physician_____
Phone_____

HEALTH HISTORY

Please know that we value your privacy. Health History information is available only to the camp health staff. The more information you provide, the better we can do our job. Thanks!

Has the camper have a history of or is prone to any of the following (Please check all that apply).

- ☐ Recent injury, illness or infectious disease
- ☐ Asthma
- ☐ Seizure Disorder or Convulsions
- ☐ Chest pain during or after exercise
- ☐ Hypertension
- ☐ Diabetes
- ☐ Chicken Pox
- ☐ German Measles
- ☐ Tuberculosis
- ☐ Joint problems (knees, ankles)
- ☐ Frequent Headaches
- ☐ Eating Disorder
- ☐ Frequent Stomachaches
- ☐ Been Hospitalized
- ☐ Chronic or recurring illness
- ☐ Frequent Ear Infections
- ☐ Dizziness during or after exercise
- ☐ Heart Defect/Disease
- ☐ Bleeding/Clotting Disorders
- ☐ Mononucleosis (in last 12 months)
- ☐ Measles
- ☐ Mumps
- ☐ Hepatitis
- ☐ Fractures
- ☐ Head Injury
- ☐ Diarrhea or constipation
- ☐ Wears glasses or contacts
- ☐ Wears a Medic Alert ID

Please provide explanation for any checked items use an additional pages if needed

_____

Attention Physician: The following Over-the-Counter medications will be available in the Health Center. Administration of these medications is "per label directions" unless otherwise noted. Generic drugs may be used in place of name brands. Please check "yes" for medications the Site Medical Staff is allowed to administer to the camper, as needed.

Yes No

____ ____ Acetaminophen: (discomfort/fever, headache, pain relief)
____ ____ Ibuprofen: (discomfort/fever, menstrual cramps, headache, muscle aches)
____ ____ Hydrogen Peroxide/Antiseptic Solution (topical, wound cleaning)
____ ____ Bacitracin/Neomycin/Polymyxin (topical, antibiotic ointment)
____ ____ Calamine/Caladryl Lotion: (topical, skin irritation)
____ ____ Hydrocortisone Cream: (topical, skin irritation)
____ ____ Ivarest Cream (topical, skin irritation)
____ ____ Cepecol Lozenges: (throat irritation, cough)
____ ____ Chloraseptic: (throat irritation)
____ ____ Robitussin: (cough suppressant, cough expectorant)
____ ____ Visine: (eye irritation)
____ ____ Benadryl: (topical for skin irritation, oral for allergies/allergy, cold symptoms)
____ ____ Claritin (allergies/allergy symptoms)
____ ____ Sudafed: (allergies/allergy symptoms, sinus, cold symptoms)
____ ____ Imodium: (diarrhea, cramps, bloating)
____ ____ Mylanta: (heartburn, acid indigestion, sour stomach, gas)
____ ____ Tums: (heartburn, sour stomach, acid indigestion, upset stomach)
____ ____ Pepto-Bismol: (nausea, heartburn, indigestion, upset stomach, diarrhea)
____ ____ Milk of Magnesia: (constipation)

Date of Last Physical Exam (Within 24 months of camp)_____

Date of Standing Orders**:** _____ Phone _____ License # _____
Signature of PHYSICIAN: _____
Printed Name_____

SECTION VII – AUTHORIZATION

My child has permission to engage in all prescribed camp activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the camp staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury.

Signature of Parent or Guardian X_____ Date_____