Sibling Connections Camp
Killam's Point Day Camp
2022 Camper Registration
9 a.m. – 8 p.m.
August 17, 2022

EMAIL REGISTRATION TO: DAWN PERROTTI – CAMP DIRECTOR: kpointcamp@gmail.com
WITH EMAIL COPY TO DR. MCNANEY – WHEELER: cmcnaney@wheelerclinic.org & JACQUELINE.FORD@CT.GOV
BY AUGUST 3RD – MUST INCLUDE HEALTH FORM

Child Name:

Date of Birth:

Town of residence:

Gender:

Sibling Name(s):

Allergies: _____
Medical Issues that prevent my child from participating in activities (SUCH AS SWIMMING, KAYACKING, FISHIING, GAMES): _____

Are there mental health needs that require clinical oversight? If yes, explain in detail:

_____.

Name of Guardian/ Foster Parent: _____

Address: _____ Cell Phone: _____ Email address: _____

Relationship to child: _____

Social Worker Name: _____ DCF Regional Office: _____

Phone Number (cell) _____ (office telephone number)

Address_____ Email: _____
Social Work Supervisor Name: _____ Cell Phone Number: _____

Emergency Contact _____ Phone_____ Relationship to Child: _____
Grade child will complete in 2022: ____
Name of School: _____

Child Pick-Up Authorization:

_____ will pick up youth at the meeting lot in Branford.
Cell number: _____
Relationship to child: _____
This person is aware that pick up time is 8:00 p.m. in Branford, Ct. [YES or NO]

The person picking up the child is required to provide photo identification.

Parent/Guardian Authorization for Application of Non-Prescription Topical Medications by Camp Nurse

I request that the below-mentioned non-prescription topical medications be administered to my child by the Camp Nurse. I understand that I am responsible for supplying the camp the non-prescription topical medication in the original container clearly labeled with my child's name. (Please sign.)

Name of non-prescription topical medication_____

Dates non-prescription topical medications shall be administered _____

Name of Parent or Guardian _____

Relationship _____

_____

Signature

If my child forgets their sunscreen or bug spray, I get permission to KPDC staff to provide sunscreen or bug spray.

I give KPDC permission to call 911 in case of an emergency. I, the parent/guardian of minor participant, recognize the possibility of physical injury, associated with the activities at camp. I hereby release, discharge and/or otherwise indemnify Killam's Point Day Camp, Killam's Point Conference Center, all personnel, against claims by or on behalf of the registrants as a result of the registrant's participation in camp programs.
If my child is ill or has a fever, I will not send my child to camp nor if he/ she is exhibiting any known symptoms of or has recently been in contact with anyone who I reasonably believe has, COVID-19.

I agree that my child will follow reasonable precautions set up by staff, including, frequent handwashing, proper social distancing, and the like. Currently, masks are required on buses, and I will provide my child with a mask for transportation.

Killam's Point Day Camp is located outdoors in a woodsy area on the ocean.
During inclement weather, camp may be moved to the First Congregational Church or may have to be canceled for the day to ensure everyone's safety.
I fully understand that there are known and potentially unknown risks of utilizing the programs. Accordingly, I will not hold Killam's Point Day Camp or its affiliates liable for any loss or damage relating to or resulting from an illness even if such loss or damage results from attendance at camp
I have read and voluntarily sign this assumption of risk and waiver of liability. I understand the information above and acknowledge that it is my responsibility to abide by Killam's Point Day Camp Policies.

By signing here, I also agree to all the above permissions, billing and waiver

Signature_____Date _____

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 SPECIFIED MEDICAL PRACTITIONER:

Date of Exam ____/____/____

_____ May participate in all camp activities

_____ May participate except for: _____

_____

Medical information pertinent to routine care and emergencies: _____

_____

Is this individual taking prescription or over the counter medication(s)? ☐ YES ☐ NO If yes, indicate names of medication(s):_____

Does the individual have allergies? ☐ YES ☐ NO Explain: _____

Is the individual on a special diet? ☐ YES ☐ NO Explain: _____

Does the individual have special needs? ☐ YES ☐ NO Explain: _____

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 Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

Comments: _____

_____

_____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town_____ST_____Zip Code_____

_____
Signature of Physician, PA, APRN or RN

_____
Date Form Signed

_____
Telephone Number