Additional Information

- Your camper will need to bring sleeping bags or sheets and blankets and towels.
- Meals will be at the Conference Center. The food at Calumet is great! If your camper has special dietary needs please let us know. Vegetarian options are always available. Coffee, juice and fruit are available all day.
- Comfortable, casual clothing is appropriate, as well as winter clothing (jacket, gloves, hat, thermal underwear, heavy socks, snow boots & pants, etc.)

Directions

From Boston: Rt 128 to 95
From Portland: Rt 25 to Rt 16
From Burlington: Rt 89 to Rt 4 to Rt 104 to Rt 25
From Hartford: Rt 84 to Rt 90 to Rt 290 to Rt 495 to Rt 95

- Take Route 95 North to Portsmouth.
- Follow signs for Rt 16 and Spaulding Turnpike.
- Follow Rt 16 past McDonalds in West Ossipee (at Rt 25).
- Take your next right onto Rt 41 -yellow blinking light -Proceed ½ mile and take a right onto the Ossipee Lake Rd (Calumet sign on corner).
- Calumet is 2.7 miles down the road.

++

Please detach and return ASAP

WINTER CAMP for KIDS February 19-22, 2018
PO Box 236
West Ossipee, NH 03890

Name_____

Mailing Address_____

Home phone (_____)_____

Email_____

Fee: $250.00 per person (payment in full required for registration)
$70.00 per person round trip for bus transportation from Worcester

Number of Campers _____

Total enclosed: _____ (Please make checks payable to CALUMET)

I am interested in charter coach transportation from Worcester: Yes No

CALUMET
LUTHERAN CAMP AND CONFERENCE CENTER
PO BOX 236
WEST OSSIPEE, NH 03890

Reservation Office 603-539-3223 Business Office 603-539-4773 FAX 603-539-3385
bonnie@calumet.org www.calumet.org

PARENT/GUARDIAN PERMISSION TO ATTEND AND PARTICIPATE IN WINTER CAMP FOR KIDS February 19 - 22, 2018

Any person who has not yet reached the age of 18 who is not being accompanied to Calumet by his or her own parent or legal guardian must have a completed form on file at the Calumet office prior to or upon arrival. A separate form must be provided for each person under 18 years of age.

NAME:_____

ADDRESS:_____

_____ZIP_____

HOME PHONE: (_____)_____

Male_____ Female_____ Date of birth:_____

Church Name:_____Town:_____

Guardian Name:_____ Work phone:(_____)_____

Cell phone (_____)_____

Guardian Name:_____Work phone:(_____)_____

Cell phone (_____)_____

If parent/guardian is not available in an emergency, notify:

Name:_____Phone:(_____)_____

Address:_____

Do you have family medical/hospital insurance? yes_____ no_____ If yes, indicate:

Carrier:_____Policy or Group #:_____

Carrier address:_____

Are there any medical conditions of which we should be aware? If so, please indicate here:

THIS FORM MUST BE SIGNED BY PARENT OR GUARDIAN

PARENT/GUARDIAN PERMISSION TO ATTEND AND PARTICIPATE

I understand and certify that my child's participation in the "2018 Winter Camp for Kids" at Calumet, and it's activities, is completely voluntary.

I recognize that there are a wide variety of activities that will take place. Events and programs that may include, but are not limited to: skiing, tubing, sliding and tobogganing; ice skating; broom ball; swimming; adventure course; boating, sailing and canoeing; soccer, softball, football, volleyball, archery, tennis and basketball; craft activities; and hiking. I acknowledge that although Calumet has taken reasonable safety precautions, Calumet cannot insure nor guarantee that the participants, equipment, premises and/or activities will be free of hazards, accidents and/or injuries. I further recognize and have instructed my child in the importance of knowing and abiding by the camp's rules, regulations and procedures for the safety of camp participants.

My signature indicates that I understand the above statement and that I hereby give permission to the medical personnel selected by the director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the director to secure and administer treatment, including hospitalization for my child. This form may be photocopied for trips off the property.

Name of Parent/Guardian_____

Please Print

Signature of Parent/Guardian_____

Please Sign

Date:_____

I _____ understand that all rules from the summer of 2017 are still
Name of participant
in place for this weekend. I further agree to abide by those rules during the weekend. Failure to follow Calumet's rules will result in contacting of parents and being asked to leave immediately.

Signature Date

How will camper be getting to Calumet, and how will they be leaving?

_____

_____

_____

_____

_____

Signature of parent or guardian Date

Calumet
2018 Winter Camp
Health History & Examination Form

PO Box 236 West Ossipee, NH 03890
603 539-3223 Fax 603 539-3385

- The information on this form is to assist us in determining appropriate care for your camper.
- Health history must be filled out by parents/guardians of minors or by adults over the age of 18.
- **A new health form completed by parent/guardian and physician is required annually.**
- **Health exam must be completed by Health Care Provider within 2 years of camp attendance.**

Name _____ Birth date_____ Age at camp _____
Last First Middle

Home address_____
Street address City State Zip

Gender: ❑ Male ❑ Female

Custodial parent/guardian _____Home Phone (_____)_____

Home address_____
(if different from above) Street address City State Zip

In an emergency, notify the following people, listed in order of preference. Please include each parent or guardian on this list.

1) Name _____ Relationship _____ Phone (_____)_____

Business Phone (_____)_____ Cell Phone (_____)_____

2) Name _____ Relationship _____Phone (_____)_____

Business Phone (_____)_____ Cell Phone (_____)_____

3) Name _____ Relationship _____Phone (_____)_____

Business Phone (_____)_____ Cell Phone (_____)_____

4) Name _____ Relationship _____Phone (_____)_____

Business Phone (_____)_____ Cell Phone (_____)_____

5) Name _____ Relationship _____Phone (_____)_____

Business Phone (_____)_____ Cell Phone (_____)_____

If traveling/vacationing when your child is at camp, please indicate how we may be able to reach you:

_____

Insurance Information

Is the participant covered by family medical/hospital insurance? ❑ Yes ❑ No
If so, indicate carrier or plan name _____ Group #_____

Please attach a photocopy of the front and back of health insurance card on a full sheet of 8 1/2 x 11 paper.

Calumet PO Box 236 West Ossipee, NH 03890
603 539-3223 Fax 603 539-3385

PARENTAL PERMISSION AND MEDICAL RELEASE

Important - Must be completed for attendance*

Parent/Guardian Authorizations:

The health history in this form is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996.

I hereby agree to the disclosure to camp representatives of the Protected Health Information of the person here-in described, as necessary: (i) To provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Calumet to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for use off camp.

I give permission for my child to be given the Over-the-Counter medications listed below (or generic equivalent), if needed, while at Calumet. Doses to be administered as per package directions. I have crossed off any medications I do not want my child to be given.

Over-the-Counter (OTC) Medication Regulations

Acetominophen
Antifungal powder or cream
Aurogan (for ear pain)
Bacitracin
Balmex
Calamine/Caladryl Lotion
Cough Drops
Zyrtec
Diphenhydramine (Benadryl)
Epinephrine for treatment of anaphylaxis(epi pen)
Hydrocortisone Cream
Ibuprofen (Motrin, Advil)
Immodium
Loratadine (Claritin)
Milk of Magnesia
Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)
Robitussin
Robitussin DM
Sore Throat Lozenges
Tums

With my signature I agree to the above parent/guardian authorizations and give my child permission to participate in all Calumet activities and programs.

Camper Name: _____ _____

↓Signature of Parent/Guardian or Adult Camper/Staffer↓

Signature _____

Print Name_____ **Date** _____

**If for religious reasons you cannot sign this, contact the camp for a legal waiver, which must be signed for attendance.*

PHOTO

Calumet PO Box 236 West Ossipee, NH 03890
603 539-3223 Fax 603 539-3385

If your camper will be given medications while at Calumet, it would be helpful if you would include a small recent photo, for identification purposes.

Health History – Camper Name: _____

The following information **must be filled in** by the parent/guardian. The intent of this information is to provide camp health care personnel the background to provide appropriate care for the camper.
PLEASE keep a copies of all completed form for your records.

ALLERGIES List all known and describe reaction and management of the reaction.

Medication allergies (list)

_____
_____
_____

Food allergies (list) -

_____
_____
_____

Other Allergies (list) include insect stings, hay fever, asthma, animal dander, etc.

_____
_____
_____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____
_____
_____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware. Have there been any recent family str**e**sses – births, deaths, illnesses, moves, separations, divorces – that will impact their camp interactions or participation? Are there strategies that have helped the camper cope with concerns in the past?

_____
_____
_____

IMPORTANT INFORMATION REGARDING MEDICATIONS TO BE TAKEN AT CAMP……

1. Any medication that your Medical Provider requires to be administered at camp must be in its original pharmacy container labeled with the name of the person, name of the medication, dosage, and frequency of administration. Please send only the correct amount of medication. Your physician's written authorization to administer medications *both prescribed and over-the-counter* meds not on the OTC list must appear on the health form.
2. All medicines are kept in the Health Center and administered by our nurses. The exceptions are: off-camp trips when Calumet staff give the medications under the direction of the nurse; asthma inhalers and epi-pens with the written authorization from your Health Care Provider for self-administration –on page six of this form. **Campers will not be allowed to carry an inhaler or epi-pen without this form.**
3. **Do not send non-prescription medications** (this includes vitamins, Tylenol, cold remedies, etc.). Our Health Center is well stocked with first aid and other medications for any conditions that might arise.
4. All medications should be picked up at the Health Center by a person age 18 or older before departing for home. All medications not picked up will be destroyed.

Calumet PO Box 236 West Ossipee, NH 03890
603 539-3223 Fax 603 539-3385

Camper Name:_____

General Questions (Explain "yes" answers below.)

Has or does the participant:

Yes			Yes		
☐	1.	Have diabetes?	☐	16.	Ever had chest pain during or after exercise?
☐	2.	Have asthma?	☐	17.	Ever had high blood pressure?
☐	3.	Ever had an eating disorder?	☐	18.	Ever been diagnosed with a heart murmur?
☐	4.	Ever had emotional difficulties	☐	19.	Ever had back problems?
☐	5.	Had any recent injury, illness or infectious disease?	☐	20.	Ever had problems with joints (e.g., knees, ankles)?
☐	6.	Have a chronic or recurring illness / condition?	☐	21.	Have an orthodontic appliance being brought to camp?
☐	7.	Ever been hospitalized?	☐	22.	Have any skin problems (e.g., itching, rash, acne)?
☐	8.	Ever had surgery?	☐	23.	Had mononucleosis in the past 12 months?
☐	9.	Have frequent headaches?	☐	24.	Have problems with diarrhea or constipation?
☐	10.	Ever had a head injury?	☐	25.	Have problems with sleepwalking?
☐	11.	Ever been knocked unconscious?	☐	26.	If female, have an abnormal menstrual history?
☐	12.	Wear glasses, contacts, or protective eye wear?	☐	27.	Have a history of bed-wetting?
☐	13.	Ever had frequent ear infections?			
☐	14.	Ever passed out during or after exercise?			
☐	15.	Ever been dizzy during or after exercise?			

Please explain any "yes" answers, noting the number of the questions.

_____

_____

_____

_____

We require an updated immunization record from a licensed health care provider.

If your camper is not immunized, we require a notarized immunization waiver. Please contact Bonnie at bonnie@calumet.org for the waiver.

Name of family physician _____ Phone (_____)_____

Address _____

Calumet PO Box 236 West Ossipee, NH 03890
603 539-3223 Fax 603 539-3385

Health Care Recommendations -To be completed by Licensed Medical Provider

You may substitute your physician's generic form for this page
as long as the information provided is comparable.

Camper Name_____ *** I EXAMINED THIS INDIVIDUAL ON_____(Date)**
(ACA accreditation and State of NH requirements specify exams within 24 months of camp attendance.)

DOB _____ Weight _____ * Height _____ *BP _____

In my opinion, the above camper ❑ is ❑ is not able to participate in an active camp program.
The camper is current on all immunizations. ❑Yes ❑No **Please include a current immunization record**
The camper is under the care of a physician for the following conditions _____
_____
_____

Recommendations and Restrictions at Camp
Treatment to be continued at camp _____
_____
_____

Medications to be administered at camp (name, dosage, frequency)
Med: _____ Dosage: _____Frequency: _____

Med: _____ Dosage: _____Frequency:_____

Med: _____ Dosage: _____Frequency:_____

Med: _____ Dosage: _____Frequency:_____

Any medically-prescribed meal plan or dietary restrictions_____
_____

Known allergies _____
_____
_____

Description of any limitation or restriction on camp activities _____
_____

Additional information for health care staff at the camp _____
_____
_____

Signature of Licensed Medical Provider – Updated signature required each year

*Signature_____

*Print Name_____

*Title _____ *Date _____

*Address _____

*Phone (_____)_____ *Fax (_____)_____

Calumet
PO Box 236
West Ossipee, NH 03890
603 539-3223 Fax 603 539-3385

ASTHMA INHALER AND EPI PEN PERMISSION FORM

Pursuant to NH Law the following must be completed and submitted 4-weeks prior to attendance in order for your child to possess and use an asthma inhaler or epinephrine auto-injector.

Camper Name_____ Date of Birth_____

Permission is granted to Camp Calumet to allow my child to possess and use an
☐ Asthma inhaler / ☐ Epinephrine Auto-Injector

Parent / Guardian Signature_____

Print name_____Date_____

LICENSED MEDICAL PERSONNEL must complete the following for use of the above
☐ Asthma inhaler / ☐ Epinephrine Auto-Injector

1) Name of medication_____
2) Date of Medication Order _____
3) Route and Dosage of Medication_____
4) Frequency and Time of Medication Administration or Assistance_____

_____

5) Diagnosis and Any Other Medical Conditions Requiring Medications _____

_____

6) Any Special Side Effects, Contraindications and Adverse Reactions to be observed? _____

_____

7) Any severe adverse reactions that may occur to another child for whom the epinephrine auto-injector is not prescribed, should such a child receive a dose of medication? _____
8) Name of each required medication_____

_____

I hereby verify that_____ has a valid prescription, and the knowledge and skills to safely possess and use the following at Camp Calumet:

☐ Asthma Inhaler ☐ Epinephrine Auto-Injector

Licensed Medical Personnel Signature_____
Date_____ Print name _____
Business Phone (_____)_____ Emergency Phone (____)_____

If any of these criteria are not met, Calumet will not be able to allow your child to carry or store an asthma inhaler or epi-pen in the cabin/tent. Please contact Calumet with any questions regarding this policy.

February 19 - 22, 2018
WINTER CAMP PICK-UP FORM
bonnie@calumet.org
PHONE: 603-539-3223 X 221 / FAX: 603-539-3385

Camper Name:_____

Parent/guardian who may pick up camper: _____

Other people who may pick up my camper (please list at least 2 other names other than parents):

1)_____

2)_____

3)_____

4)_____

I authorize any of the above people to pick up my camper.

☐ **My camper will be picked up at Calumet**

☐ **My camper will be picked up at the Bus stop at Trinity Lutheran Church in Worcester at 4:00 pm on Thursday February 22, 2018**

☐ **My camper will be riding with another Camper _____**

Parent/Guardian Signature:_____

FOR USE ON THE DAY OF PICK-UP

Signature of person picking up camper: _____

Date: _____