

# Camp Holy Cross 2008

## SUMMER CAMP FOR BOYS AND GIRLS

Funded in part by the Roman Catholic Diocese of Springfield Annual Catholic Appeal

Students may enroll for multiple weeks. Use separate form for each applicant. Camper must be appropriate age at the start of session.

### Traditional Youth Camp

- Session I - Ages 8-15 July 6-11, 2008     Session II - Ages 8-15 July 13-18, 2008

### Junior Counselor Training Camp

- Session I - Ages 14-15 July 6-11, 2008     Session II - Ages 14-15 July 13-18, 2008  
14 & 15 Year Old Students have choice between either program.  
~ (Session I & II = Sunday Night - Friday Noon) ~

- Applicant has attended Camp Holy Cross     Applicant is a first time camper

Camper Name \_\_\_\_\_

Male     Female    T-Shirt Size (adult) S\_\_\_ M\_\_\_ L\_\_\_ XL\_\_\_

Age (upon arrival) \_\_\_\_\_ Birth date \_\_\_\_\_

Telephone \_\_\_\_\_ EMAIL (parent) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Postal Code \_\_\_\_\_

Parish \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Name of Parent/Guardian \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

Emergency Contact (other than parent /guardian) \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

### SPECIAL INSTRUCTIONS

List any special instructions we should follow to care for your child. Include any health issues, restriction, allergies, and medications

### BUNK REQUESTS

**YOUR CHILD MAY REQUEST TO BUNK WITH ONE FRIEND.** Multiple requests will not be fulfilled. **THE FRIEND INDICATED MUST ALSO REQUEST YOUR SON OR DAUGHTER ON THEIR FORM.** Both campers must be in the same session. We will try to accommodate these requests to the best of our ability.

My child would like to bunk with : \_\_\_\_\_ (only one name please - Be sure bunkmate makes the same selection on their application form.) Call prior to camp if this changes!

**The Applicant has my approval to participate in all regular camp activities. His / Her name or picture may appear in camp publications. I also agree to all charges and policies outlined on this form.**

**Signature of Parent / Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

Massachusetts State Law requires a Medical Form be completed by your doctor prior to your child attending a residential camp. This form will be provided for your completion.

# CAMP HOLY CROSS YOUTH RECREATION CAMP 2008

**Recreation . . . Water Fun . . . Camp-Wide Events . . . Special Activities . . . Faith Based Activities . . .**

## CAMP PHILOSOPHY

The purpose of our camp is to provide a Christian educational experience in outdoor living. Our programs are oriented to the Roman Catholic philosophy of outdoor ministry, which shall encompass recreation for young people, shall be ecologically sound and shall be geared toward developing a greater sense of the presence of God in one's life. For this reason, all our counselors and volunteers of the camp put the health and safety of the campers in the forefront at all times.

## WHO WORKS AT CAMP HOLY CROSS

Fr. Chris Malatesta is the Director of Holy Cross Campgrounds and oversees the summer youth camping sessions. Angela Slowinski (Med) is the resident Session Director who oversees the daily operation, coordination and scheduling of our youth camping program and Kevin Callahan (MS Candidate) oversees the CIT Program. We are assisted by a mature staff of high school & college students and adults who provide a creative camping program designed to meet the individual needs of each camper. Our enthusiastic staff supervises the campers in their living quarters and motivates them as they proceed through our fun-filled program. The campers are grouped by division of age. A strong emphasis is placed on safety. Our staff's goal make a young camper feel more secure and encourages trust and confidence while providing a rewarding summer camp experience.

## LOCATION

Camp Holy Cross has been a facility in the Diocese of Springfield since 1930 and contains over 250 acres of woods and fields situated on the beautiful Upper Highland Reservoir in the Berkshire Hills. It is located on Route 112 North (one mile off route 9) in Goshen, MA.

## CAMP HOLY CROSS SUMMER CAMP FEES 2008

Camp Costs \$250.00 per camper / per week for Session I & II of either the Traditional Youth Camp or Counselor in Training Program. Cost is all inclusive of meals, lodging and activities. A \$50 Non-Refundable Deposit must accompany the application. The \$200 Balance is due one month prior to start of camp.

**A \$50 MULTI SESSION OR MULTI CHILD DISCOUNT IS AVAILABLE PER CHILD** if you have a child attending Session I & II; multiple siblings attending Session I or II or both.

The deposit shall be applied to the total tuition. The deposit will not be refunded in the event of withdrawal. The remaining balance is due at least one month prior to the beginning of the session. There will be no reduction of fees for early departure or late arrival. Should a camper withdraw or be asked to leave due to behavior problems after the start of camp, tuition will not be refunded unless withdrawal is for medical reasons recommended by our nursing staff. A refund will not be made for homesickness.

## **SAFETY FIRST**

Our Camp is a licensed Recreational Children's Camp and is monitored by the local Board of Health. Our Staff is CORI Certified and carefully screened to ensure the safety of your child. We have a full time RN on premises and licensed physician on call. A phone is available for use by our campers. Local police, fire and emergency services are available to the camp. Our entire camp staff is Red Cross CPR and First Aid Certified. We are in compliance with the Diocese of Springfield's Charter on the Protection of Children.

**VISIT US ON THE WEB FOR MORE INFORMATION AND PRINTABLE FORMS**

**[WWW.CAMPOLYXCROSS.ORG](http://WWW.CAMPOLYXCROSS.ORG)**

Mail completed applications to Camp Holy Cross, 489 Main Street, Dalton, MA 01226

# Health History and Examination Form for Children, Youth and Adults Attending Camps

FM 08N

**Suggested for resident camp use.**

Developed and approved by  
**American Camping Association®**  
American Academy of Pediatrics  
Expires 10/31/04

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians of minors or by adults

Dates of Camp Attendance \_\_\_\_\_

Mail this form to the address below by \_\_\_\_\_ (date)

themselves. Update required annually. Health exam (back page) must be completed by approved licensed medical personnel at least every two years.

Year

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_  
Last First Middle

Home address \_\_\_\_\_  
Street address City State Zip

Social security number of participant \_\_\_\_\_ Gender:  Male  Female

Custodial parent/guardian \_\_\_\_\_ Phone \_\_\_\_\_

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

Business address \_\_\_\_\_ Phone \_\_\_\_\_  
Street address City State Zip

Second parent or guardian or emergency contact \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street address City State Zip

Business address \_\_\_\_\_ Phone \_\_\_\_\_

If not available in an emergency, notify:

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street address City State Zip

### Insurance Information

Is the participant covered by family medical/hospital insurance?  Yes  No

If so, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

► **Photocopy of front and back of health insurance card must be attached to this form.**

### Important — These boxes must be complete for attendance\*

<p><b>Parent/Guardian Authorizations:</b> This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.</p> <p>I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment,</p> <p>Signature of parent/guardian or adult camper/staffer _____</p> <p>Printed Name _____ Date _____</p>	<p>referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.</p> <p>In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.</p>
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<p>I also understand and agree to abide by any restrictions placed on my participation in camp activities.</p> <p>Signature of minor or adult camper/staffer _____ Date _____</p>
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Cabin or Group

Name

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

# Health History

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the

completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

**ALLERGIES** List all known.

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.

_____	_____
_____	_____
_____	_____

## MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original

packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Attach additional pages for more medications.  
Identify any medications taken during the school year that participant does/may not take during the summer: \_\_\_\_\_  
\_\_\_\_\_

## RESTRICTIONS

The following restrictions apply to this individual.

### Dietary

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Does not eat red meat  | <input type="checkbox"/> Does not eat pork    | <input type="checkbox"/> Does not eat eggs           |
| <input type="checkbox"/> Does not eat poultry   | <input type="checkbox"/> Does not eat seafood | <input type="checkbox"/> Does not eat dairy products |
| <input type="checkbox"/> Other (describe) _____ |   |  |

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

_____
_____
_____



**Health Care Recommendations by Licensed Medical Personnel**

I examined this individual on \_\_\_\_\_. (ACA accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.)

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant  is  is not able to participate in an active camp program.

The applicant 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)

\_\_\_\_\_  
\_\_\_\_\_

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 Personnel** \_\_\_\_\_  
Printed \_\_\_\_\_ Title \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_ Date \_\_\_\_\_

*For camp use only*

**Screening Record**  
Date screened \_\_\_\_\_ Time \_\_\_\_\_ am  
pm  
Meds received \_\_\_\_\_  
\_\_\_\_\_  
Updates/additions to health history noted  Yes  No  None required  
Current health needs identified \_\_\_\_\_  
\_\_\_\_\_  
Observational notes \_\_\_\_\_  
\_\_\_\_\_  
Screened by \_\_\_\_\_

CAMP HOLY CROSS 2008

Dear Parent or Guardian. Please fill in the following information and return to camp along with the four page Health History Form. This information is important in case of mild illness or emergency during camp. Must complete one per camper.

Birthdate \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Father \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother \_\_\_\_\_ Work Phone \_\_\_\_\_

Guardian \_\_\_\_\_ Work Phone \_\_\_\_\_

If parent cannot be reached in an emergency, names of responsible adults to call who may pick up your child:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Has student been seen by his/her physician in the last two years? \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize you to call my family physician if I cannot be reached and such a call is considered necessary.

Child's Health Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

I give permission to have the camp nurse or delegate (if applicable) to administer the following:  
(Doses determined by age and weight)

- |                              |                      |                       |                       |
|------------------------------|----------------------|-----------------------|-----------------------|
| ◇ All of the following       | ◇ Benadryl           | ◇ Antibiotic ointment | ◇ Bacitracin Ointment |
| ◇ None of the following      | ◇ Antacid            | ◇ Cough Drops         | ◇ Cortisone Ointment  |
| ◇ Acetaminophen<br>(Tylenol) | ◇ Ibuprophen (Advil) | ◇ Insect Repellent    | ◇ Insect Bite Swab    |
|                              |                      |                       | ◇ Sunscreen           |

Signature of Parent/ Guardian \_\_\_\_\_ Date \_\_\_\_\_