CAMP TOTOKETT MENTOR REGISTRATION

August 1 – 5, 2022

NAME: _____ Birth Date: _____

Gender Identity: Male ☐ Female ☐ Non-binary ☐ Prefer not to say ☐

What pronouns do you prefer us to use at camp? _____

Address: _____ City: _____ State: ____ Zip: _____

Email:_____

Cell Phone:_____

Please list any special needs or Information:

_____

Medication:_____

Allergies:_____

Emergency Contact Information:

Name of person to contact: _____ Relationship: _____

Home phone #: _____ Work/Cell phone #: _____

Name of person to contact: _____ Relationship: _____

Home phone #: _____ Work/Cell phone #: _____

Adult T-shirt Size: AS AM AL AXL (select one for staff shirt)

Photo Release: I will/will not (circle one) allow my child's picture to be used in Church Publicity for Camp Totokett.

***PHYSICALS: All* volunteers must have a current physical form on file to volunteer at camp – it is a state requirement. *By agreeing to volunteer, you agree to furnish us with this form prior to the first day of camp*. Physicals are valid for three years from the date of your last exam.**

MENTOR SIGNATURE: _____ Date:_____

PARENT/GUARDIAN SIGNATURE: _____ Date: _____
(Not required if Mentor is 18 years or older)

Mail or Email your completed form to:
Hailey Nelson
c/o Camp Totokett
24 Reynolds Avenue
Branford, CT 06405

If you have any questions or concerns please do not hesitate to contact us!
Email: camptotokett@gmail.com
Phone: (203) 859-1320

Return to:
Hailey Nelson
c/o Camp Totokett
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Branford, CT 06405
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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: **August 1, 2022** Departure Date: **August 5, 2022**

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