CAMP TOTOKETT August 1-5, 2022
ADULT STAFF REGISTRATION

Name: _____
Gender Identity: Male ☐ Female ☐ Non-binary ☐ Prefer not to say ☐
What pronouns do you prefer us to use at camp? _____
Email: _____
Phone-Home: _____ Cell: _____ Work: _____
Address: _____ City: _____ State: ___ Zip: _____

Please list any Special Needs or Information:
_____

Medication(s):_____
Allergies:_____

Emergency Contact Information:
Name: _____ Relationship: _____ Phone:_____
Name: _____ Relationship: _____ Phone:_____

***All* adult volunteers/staff members 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*. Even if you will only be on premises for one activity, a Physical Form and Registration Form are required. Physicals are valid for three years from the date of your last exam.**

Staff Signature: _____ Date: _____

Please mail or email your completed Registration & Medical Forms to:

Hailey Nelson
c/o Camp Totokett
24 Reynolds Avenue
Branford, CT 06505

Telephone: (203) 859-1320
Email: camptotokett@gmail.com

Return to:
Hailey Nelson
c/o Camp Totokett
24 Reynolds Avenue
Branford, CT 06405
Phone: (203) 859-1320
Email: camptotokett@gmail.com

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