

CAMP TOTOKETT  
Killam's Point, Branford, Connecticut July 21 – 25, 2025  
**CAMPER REGISTRATION FORM**

| Camper Information   | Parent/Guardian Information   |
|--|---|
| Camper's Name _____  | Parent/Guardian Name _____  |
| Address _____  | Relationship _____  |
| _____  | Address _____   |
| _____  | _____   |
| Date of Birth _____  | _____   |
| Age at Start of Camp _____   | Email: _____  |
|  | Phone # _____   |
| Camper's Gender Identity   |   |
| Male   | <b>Emergency Contact Name</b> _____   |
| Female   | <b>Relationship</b> _____   |
| Non-binary   | <b>Emergency Contact Phone #</b> _____  |
| Prefer not to say  |   |
| What pronouns does your child prefer us to use at camp?                          | <b>COVID-19 Vaccination Status</b>  |
| He/him/his   | We strongly encourage all campers to be vaccinated prior to the start of our camp week. |
| She/her/hers   |   |
| They/them/theirs   | Has your child been vaccinated?   |
| Other: _____   | Yes   |
|  | No  |
| School Grade, 2024-2025 _____  | If yes, please provide the dates of their vaccine:                                      |
| Name and location of school  | Dose 1: _____   |
| _____  | Dose 2: _____   |
| _____  |   |
| _____  |   |
| Please indicate the agency affiliation for each child or family (if applicable): |   |
| Nathan Smith Clinic  | APNH  |
| Fair Haven Community Health  | Hill Health Center  |
| Hispanic Health Council  | St. Raphael's Haelen Clinic   |
|  | Yale Child Studies  |
|  | IRIS  |
|  | Sanctuary Kitchen   |
| Camp T-Shirt Size Preference (please select one):                                |   |
| Youth: <b>S</b> <b>M</b> <b>L</b> <b>XL</b>                                      |   |
| Adult: <b>AS</b> <b>AM</b> <b>AL</b> <b>AXL</b> <b>AXXL</b> <b>AXXXL</b>         |   |

**PLEASE NOTE:**

- A separate **Registration Packet** is required for each camper if multiple children are attending
- Medical forms are required
- Registration forms are due by **June 30, 2025**.
- Return this form to:

**Hailey Nelson**  
c/o Camp Totokett  
24 Reynolds Avenue Branford, CT 06405  
Telephone: (203) 859-1320  
Email: [camptotokett@gmail.com](mailto:camptotokett@gmail.com)

**CAMP TOTOKETT**  
Killam's Point, Branford, Connecticut  
July 21- 25, 2025  
**CAMPER PERMISSION FORM**

I give my permission for (**Camper's Name**) \_\_\_\_\_  
to attend Camp Totokett and to participate in all activities including transportation to and  
from camp, except as noted by the Licensed Health Care Provider.

The Camp Director reserves the right to send the Camper/Counselor home if illness or  
other significant reason so dictates.

I give permission to the medical personnel/director to order/administer medical treatment,  
release medical records for insurance purposes, and provide or arrange necessary  
transportation.

**Signature** \_\_\_\_\_

If any action is required, I may be reached at:

**Phone#** \_\_\_\_\_ **Address** \_\_\_\_\_

If I cannot be reached, the following person has consented and has permission to care  
for the Camper:

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone#** \_\_\_\_\_

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

**Print Name:** \_\_\_\_\_

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

If you have any questions or concerns, please do not hesitate to contact us!

**Email:** [camptotokett@gmail.com](mailto:camptotokett@gmail.com)

**Telephone:** (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: July 21, 2025 Departure Date: July 25, 2025

**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