



CAMP TOTOKETT July 20 – 24, 2026 ADULT STAFF REGISTRATION

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: _____

COVID-19 Vaccination Status

We strongly encourage all volunteers to be vaccinated prior to the start of our camp week.

Have you been vaccinated?

Yes

No

Please list any special needs or Information:

Medication: _____

Allergies: _____

If yes, please provide the dates of your vaccination:

Dose 1: _____

Dose 2: _____

Booster: _____

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 AXXL AXXXL (select one for staff shirt)

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 06405**

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

Email: camptotokett@gmail.com

Phone: (203) 859-1320

SAMPLE FORM

**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: _____ Departure Date: _____

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