CAMP TOTOKETT
Killam's Point, Branford, Connecticut July 20 – 24, 2026
CAMPER REGISTRATION FORM

Camper Information

Camper's Name_____
Address_____
_____
_____

Date of Birth _____
Age at Start of Camp _____

Camper's Gender Identity
Male
Female
Non-binary
Prefer not to say

What pronouns does your child prefer us to use at camp?
He/him/his
She/her/hers
They/them/theirs
Other: _____

School Grade, 2024-2025 _____

Name and location of school
_____
_____
_____

Parent/Guardian Information

Parent/Guardian Name_____
Relationship _____
Address _____
_____
_____

Email: _____
Phone # _____

Emergency Contact Name _____
Relationship _____
Emergency Contact Phone # _____

COVID-19 Vaccination Status

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

Has your child been vaccinated?
Yes
No

If yes, please provide the dates of their vaccine:
Dose 1: _____
Dose 2: _____

Please indicate the agency affiliation for each child or family (if applicable):

Nathan Smith Clinic	APNH	Yale Child Studies
Fair Haven Community Health	Hill Health Center	IRIS
Hispanic Health Council	St. Raphael's Haelen Clinic	Sanctuary Kitchen

Camp T-Shirt Size Preference (please select one):

Youth: **S** **M** **L** **XL**

Adult: **AS** **AM** **AL** **AXL** **AXXL** **AXXXL**

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 **July 1, 2026**.
- Return this form to:

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

CAMP TOTOKETT

Killam's Point, Branford, Connecticut
July 20 - 24, 2026
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
Telephone: (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