

**PLEASE RETURN BY APRIL 1<sup>st</sup> TO:**  
**WINTER** (September 1 - May 15)  
3 New King Street, White Plains, NY 10604  
p: 914-437-7200 f: 914-422-3635

**SUMMER** (May 16 - August 31)  
700 Churchill Street, Pittsfield, MA 01201  
p: 413-447-8900 / 800-494-6238  
f: 413-447-8905

# **CAMPER CODE OF BEHAVIOR 2012: UNPLUGGED/BULLYING/ELECTRONICS POLICY**

## **TO BE SIGNED BY PARENT/GUARDIAN AND ALL CAMPERS IN THE FAMILY:**

We are all aware that children do not leave home without their personal electronics such as cell phones, laptops, and iPods. As a result of this trend we, along with many camp directors, are deciding what kind of electronics we will permit in camp. Why do we need to address this issue? Electronics allow for solitary play which directly conflicts with the goal of camp. Camp is about developing interdependence, social skills, and gaining self-confidence. Electronics interferes with our philosophy of camping, which is to develop a well rounded individual. Therefore we will not permit campers to utilize or have in their possession the following items:

**CELL PHONES, BLACKBERRIES, LAPTOPS, COMPUTERS, GPS DEVICES, OR ANY DEVICES THAT SHOW VIDEOS, OR ACCESS THE INTERNET.**

## **CAMP WINADU IS NOT RESPONSIBLE FOR ANY LOST OR STOLEN ITEMS.**

**Camp Winadu reserves the right to dismiss any camper from camp if the camper is found in possession of illegal narcotics, alcoholic beverages, weapons, or if the camper does not follow the rules and responsibilities.**

At Camp Winadu, bullying is inexcusable. We have a firm policy against all types of bullying, whether it is physical, verbal or occurring via cyberspace.

We have partnered with experts at the ACA (American Camp Association) to deliver our message to our families. We expect every camper to respect the rights of others, and to be aware that we will not tolerate any form of bullying at the expense of someone else. We want to make sure that every camper makes friends and has a great camp experience filled with lots of memories. Campers who fail to adhere to our anti-bullying policy will lose the privilege to participate in our summer camp experience.

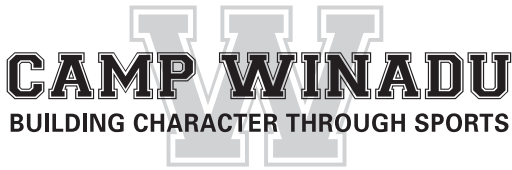
Family Last Name \_\_\_\_\_ Phone \_\_\_\_\_

Camper(s) Signature(s) 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_



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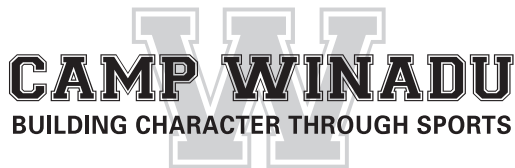
# CAMPER HEALTH HISTORY FORM 2012

**TO BE COMPLETED BY PARENT / GUARDIAN**

Camper Name (First, Middle, Last) \_\_\_\_\_ Birth Date \_\_\_\_\_

Camper Home Address: _____ City _____ State _____ Zip Code _____ <b>Parent/guardian with legal custody to be contacted in case of illness or injury:</b> Name: _____ Relationship to Camper: _____ Email _____ Home Phone: (____) _____ Cell: (____) _____ Summer Phone if different: (____) _____ Home Address (If different from above): _____ City _____ State _____ Zip Code _____ <b>Second parent/guardian or other emergency contact:</b> Name: _____ Relationship to Camper: _____ Email _____ Home Phone: (____) _____ Cell: (____) _____ Summer Phone if different: (____) _____ <b>Additional contact in event parent(s)/guardian(s) can not be reached:</b> Name(s): _____ Relationship to Camper: _____ Home Phone: (____) _____ Cell: (____) _____
<b>Allergies:</b> <input type="checkbox"/> No known allergies. <input type="checkbox"/> This camper is allergic to: <input type="checkbox"/> Food <input type="checkbox"/> Medicine <input type="checkbox"/> The environment (insect stings, hay fever, etc.) <input type="checkbox"/> Other <i>(Please describe below what the camper is allergic to and the reaction seen.)</i>
<b>Diet, Nutrition:</b> <input type="checkbox"/> This camper eats a regular diet. <input type="checkbox"/> This camper eats a regular vegetarian diet. <input type="checkbox"/> This camper has special food needs. <i>(Please describe below.)</i>
<b>Restrictions:</b> <input type="checkbox"/> I have reviewed the program and activities of the camp and feel the camper can participate without restrictions. <input type="checkbox"/> I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. <i>(Please describe below.)</i>
<b>Medical Insurance Information:</b> This camper is covered by family medical/hospital insurance <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.</b> Insurance Company _____ Policy Number _____ Subscriber _____ Insurance Company Phone Number (____) _____
<b>Parent/Guardian Authorization for Health Care:</b> This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status. Signature of Custodial Parent/Guardian _____ Date: _____ Relationship _____ to Camper: _____ <i>If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.</i>





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# CAMPER PERSONAL INFORMATION FORM 2012

Camper's Name \_\_\_\_\_ Nickname \_\_\_\_\_  
First, Last (Please Print)

Camper's Email \_\_\_\_\_ @ \_\_\_\_\_ Parent's Email \_\_\_\_\_ @ \_\_\_\_\_

T-Shirt Size:  Youth S  Youth M  Youth L  Adult S  Adult M  Adult L  Adult XL

**Name** **Age** **Camp**

Siblings at Camp \_\_\_\_\_  
 \_\_\_\_\_

Bunkmate requests \_\_\_\_\_  
 \_\_\_\_\_

Bunkmate objections \_\_\_\_\_  
 \_\_\_\_\_

Is there any change in marital status that would be important for us to know about?  Yes  No

If yes, should there be a double mailing?  Yes  No

If yes, please indicate a second address: (Dr/Mr/Mrs) \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## OPTIONAL PROGRAMS

Please enroll my son in the following optional programs:  Ice Hockey - \$600  Golf - \$600  Partial Golf - \$300

## TRANSPORTATION INFORMATION

How will your son get to camp?  Drive  Special Arrangements \_\_\_\_\_

Fly If yes, please indicate from where:  Florida  Santo Domino  Other \_\_\_\_\_

Bus (Please choose from the following departure locations. See Parent Handbook for details):

Manhattan  Livingston, NJ  Montvale, NJ  White Plains, NY  Long Island  Philadelphia

## GENERAL INFORMATION

Does your son: Need to Attend Church?  Yes  No

Need Bar Mitzvah Tutoring?  Yes  No

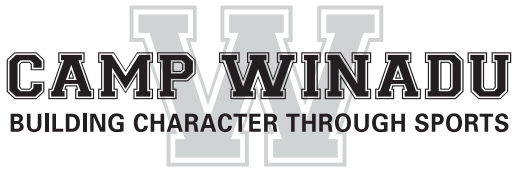
Have an upcoming Bar Mitzvah this year?  Yes  No If yes, date \_\_\_\_\_

Need School Tutoring?  Yes  No

If yes, which subjects? \_\_\_\_\_

(OVER)





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MEDICATION INSTRUCTION FORM 2012

Camper's Name \_\_\_\_\_
First, Last (Please Print)

Age \_\_\_\_\_ Division \_\_\_\_\_ Date of Birth \_\_\_\_\_

Routine Medications: Please list below all medications that your child will be taking on a daily basis.
Please include any eye drops, vitamins, topical creams, etc. that you will be sending to camp for daily use.

Table with 4 columns: Name of Medication, Dosage, Frequency, Reason for Medication. Rows 1-4.

Medications to be taken only as needed:

Table with 4 columns: Name of Medication, Dosage, Frequency, Reason for Medication. Rows 1-4.

Does your child take allergy shots? [ ] Yes [ ] No If so, when was the last one given prior to camp? \_\_\_\_\_

When is the next injection due? (day and date please) \_\_\_\_\_

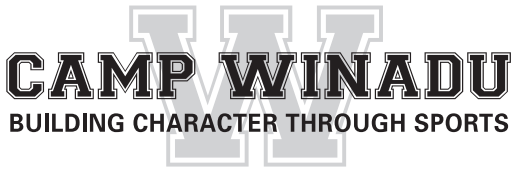
Please list below allergy shots to be given, frequency and details:

Blank lines for listing allergy shots.

Allergy Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize medication to be given as listed above.



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## SUMMER ADDRESS FORM 2012

**Camper(s) Name** \_\_\_\_\_  
First, Last (Please Print)

**Parents Names** \_\_\_\_\_  
First, Last - if different (Please Print)

Please provide us with your summer address and contact information:

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Fax \_\_\_\_\_

When There (e.g. weekends, etc) \_\_\_\_\_

Father's Cell Phone \_\_\_\_\_ Mother's Cell Phone \_\_\_\_\_

Father's Email Address \_\_\_\_\_ Mother's Email Address \_\_\_\_\_

\*Relative or person to contact in case of an emergency and the camp cannot locate you:

Name \_\_\_\_\_ Relationship to You \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Fax \_\_\_\_\_

**Name of Child's Physician** \_\_\_\_\_

Physician's Office Phone \_\_\_\_\_ Physician's Home Phone \_\_\_\_\_

**Mother's Business:** Name of Firm \_\_\_\_\_ Phone \_\_\_\_\_

**Father's Business:** Name of Firm \_\_\_\_\_ Phone \_\_\_\_\_

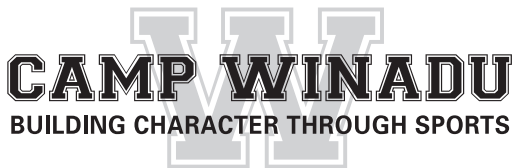
**Name of Country Club that Parents May Frequent:** Please tell us the most common times that you are there.

Name of Club \_\_\_\_\_

Phone \_\_\_\_\_ When There \_\_\_\_\_

Please attach or write on the reverse side your summer itinerary if you plan to travel.

**\* If you plan to be out of the country during the summer, please provide us with an authorized emergency contact.**



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# CAMPER MEDICAL FORM 2012

## TO BE COMPLETED BY PHYSICIAN

Camper Name (First, Middle, Last) \_\_\_\_\_

Birth Date \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent / Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_

<p>The following non-prescription medications are commonly stocked in camp Health Centers and are used on an <u>as needed basis</u> to manage illness and injury. <b>Medical personnel: Cross out those items the camper should <u>not</u> be given.</b></p> <p>Acetaminophen (Tylenol)          Ibuprofen (Advil, Motrin)          Phenylephrine (Sudafed PE)          Pseudoephedrine (Sudafed)          Chlorpheniramine maleate          Guaifenesin          Dextromethorphan          Diphenhydramine (Benadryl)          Generic cough drops          Chloraseptic (Sore throat spray)          Lice shampoo or scabies cream          Calamine lotion          Bismuth subsalicylate (Pepto-Bismol)          Laxatives for constipation (Ex-Lax)          Hydrocortisone 1% cream          Topical antibiotic cream          Calamine lotion          Aloe</p>	<p style="border-top: 1px dashed black; border-bottom: 1px dashed black;"><b>Medical Personnel:</b> Please review the Camper Health History Form and complete all remaining sections of this form. Attach additional information if needed.</p> <p><b>Physical exam done today:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," date of last physical: _____)  <small style="margin-left: 200px;">Month/Day/Year</small></p> <p><b>ACA accreditation standards specify physical exam within last 12 months.</b></p> <p>Weight: _____ lbs Height: _____ ft _____ in Blood Pressure _____ / _____</p> <p><b>Allergies:</b> <input type="checkbox"/> No Known Allergies</p> <p><input type="checkbox"/> To foods (<b>list</b>):</p> <p><input type="checkbox"/> To medications: (<b>list</b>):</p> <p><input type="checkbox"/> To the environment (<b>insect stings, hay fever, etc.— list</b>):</p> <p><input type="checkbox"/> Other allergies: (<b>list</b>):</p> <p><b>Describe previous reactions:</b></p>
<p><b>Diet, Nutrition:</b> <input type="checkbox"/> Eats a regular diet. <input type="checkbox"/> Has a medically prescribed meal plan or dietary restrictions: (<b>describe below</b>)</p>	
<p><b>The camper is undergoing treatment at this time for the following conditions:</b> (<b>describe below</b>) <input type="checkbox"/> None.</p>	
<p><b>Medication:</b> <input type="checkbox"/> No daily medications. <input type="checkbox"/> Will take the following prescribed medication(s) while at camp: (<b>name, dose, frequency—describe below</b>)</p>	
<p><b>Other treatments/therapies to be continued at camp:</b> (<b>describe below</b>) <input type="checkbox"/> None needed.</p>	
<p>Do you feel that the camper will require limitations or restrictions to activity while at camp? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p style="border: 1px dotted black; padding: 5px; margin-top: 5px;"><b>If you answered "Yes"</b> to the question above, what do you recommend? (<b>describe below—attach additional information if needed</b>)</p>	
<p><b>"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)"</b></p> <p>Name of licensed provider (please print): _____ Signature: _____ Title: _____</p> <p>Office Address _____  <small style="margin-left: 20px;">Street</small> <span style="margin-left: 150px;"><small>City</small></span> <span style="margin-left: 100px;"><small>State</small></span> <span style="margin-left: 50px;"><small>Zip Code</small></span></p> <p>Telephone: (_____) _____ Date: _____</p>	
<p>Copyright 2008 by American Camping Association, Inc. <span style="float: right;">Rev. 2/07 LEE/EAW</span></p>	

**OVER**

Camper Name: \_\_\_\_\_  
 First Middle Last  
 Birth Date: \_\_\_\_\_  
 Month/Day/Year

**Immunization History:** Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis ★ (DTaP) or (TdaP)						
Tetanus booster ★ (dT) or (TdaP)						
Mumps, measles, rubella ★ (MMR)						
Polio ★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) <input type="checkbox"/> Had chicken pox Date: _____						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test Date:  Negative  Positive

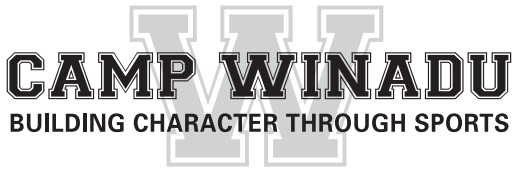
**Medication:**  This camper will not take any daily medications while attending camp.  
 This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

- |   |   |
|---|---|
| Acetaminophen (Tylenol)                                   | Ibuprofen (Advil, Motrin)                                     |
| Phenylephrine decongestant (Sudafed PE)                   | Pseudoephedrine decongestant (Sudafed)                        |
| Antihistamine/allergy medicine                            | Guafenesin cough syrup (Robitussin)                           |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Dextromethorphan cough syrup (Robitussin DM)                  |
| Sore throat spray   | Generic cough drops   |
| Lice shampoo or cream                                     | Antibiotic cream  |
| Calamine lotion   | Aloe  |
| Laxatives for constipation (Ex-Lax)                       | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |



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Camper(s) Name \_\_\_\_\_

First, Last (Please Print)

HIPPA/AUTHORIZATION FOR COMMUNICATION WITH MEDICAL PERSONNEL 2012

I \_\_\_\_\_, parent or guardian of the above named camper, authorize any physician, nurse or other health care provider to communicate with the medical staff and directors of Camp Winadu, or their designees, about my child's medical condition, treatment and/or prognosis.

I further authorize the medical staff of Camp Winadu to discuss any medical conditions with the directors, their designees, or my child's counselors when the medical staff, in its sole discretion, believes such communication to be in the best interest of the child.

These authorizations are limited to June 15, 2012 through August 20, 2012.

AUTHORIZATION FOR ADMINISTERING OVER THE COUNTER MEDICATION 2012

I give permission for Camp Winadu to administer the following over the counter medications if the infirmary staff deems it necessary. Dosages will be administered according to the directions on the bottle unless a physician directs otherwise.

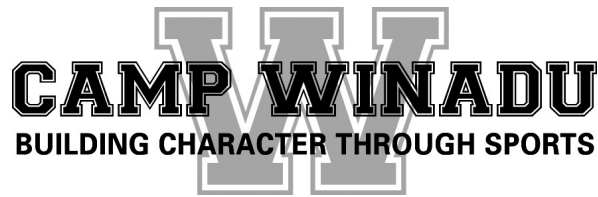
- Tylenol • Ibuprofen • Pepto Bismol / Mylanta • Cough / Cold Medications (e.g. Sudafed / Benadryl)
• Immodium AD • Topical Preparations (e.g. Calamine / Cortaid)

I give permission to the medical personnel to provide routine health care to administer medications, to order X-rays, routine tests, treatments and to release any records necessary.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment including hospitalization for my child. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Printed Parent Name \_\_\_\_\_ Phone \_\_\_\_\_



Dear Camp Parents,

This summer Camp Winadu will continue its partnership with **CVS Pharmacy** in Pittsfield, MA to administer medications. **All prescription pills that your child takes on a daily or as needed basis** will be dispensed by CVS Pharmacy and individually packaged, sealed and sorted according to day and time of administration. **This includes all prescription medications.** Each individually sealed packet will be labeled with your child's name, medicine, dosage, date and time to be given. The CVS system ensures that each camper receives their correct medicine at the correct time.

All medication will be picked up by the camp, prior to your child's arrival. All unused medication will be sent home by the camp.

***What you need to do:***

If your camper regularly takes a prescription medication in pill form, you should fill out the Camper information sheet and fax it in to **CVS Pharmacy**.

1. *Request that your Doctor indicate "Camp Winadu" along with your child's name on your prescription.* All prescription medications in pill form must be called or faxed into **CVS Pharmacy in Pittsfield, MA** by your child's doctor's office. If you have written prescriptions you are also welcome to mail them to CVS. If your family already uses CVS Pharmacy in another area, CVS is able to retrieve any prescriptions that have been filled at a CVS Pharmacy. *Any Schedule II medications (i.e., Ritalin, Adderall, Concerta, etc.) must be mailed. These medications **cannot** be phoned or faxed in.*
2. CVS will need prescriptions for all medications that your child will be taking this summer. The pharmacy will need time to get them ready for the first day of camp. CVS will not be able to fill and package any medications that they have not filled at the Pittsfield location.
3. Please make sure to provide CVS Pharmacy with an alternative phone number (i.e., cell phone) if they need to contact you for any insurance or billing questions.
4. Please fill out the CVS Pharmacy information form about your camper. You will need to fill out the form and either fax or mail it back to CVS Pharmacy.

**CVS Pharmacy: Pittsfield, MA**

107 West Street

Pittsfield, MA 01201

Phone: (413) 499-4624

Fax: (413) 448-2583

**Fees:** There is **no fee** to use this CVS Pharmacy service. However, you are responsible for the cost of the medication co-payments and the deductibles to your insurance company, which will appear on your credit card statement. This cost will be charged to your credit card.

**Insurance/Prescription Medication:** **CVS Pharmacy** accepts most insurance plans. They will verify your insurance, and bill for prescription drugs. You are responsible for the co-payments and deductibles which will appear on your credit card statement during the summer months after your child is in camp, or after returning home. You are responsible to notify **CVS Pharmacy** of any changes to your credit card and/or insurance plan. If the pharmacy is not a provider for your plan, you will be notified and given the option to contact camp for alternative arrangements. If CVS is unable to bill the insurance company, they will contact you directly. If they are unable to reach you before the child needs the medication, the insurance may not be billed. In the case that the insurance is not billed by CVS, the prescription will be charged to your credit card.

**Medication Not Covered by Insurance:** These will be charged to your credit card by **CVS Pharmacy**.

## FREQUENTLY ASKED QUESTIONS

1. How will CVS Pharmacy know what prescriptions to fill for my child?  
***Each camper will have an information sheet. On that information sheet there is a place to list all medications that are expected on day one at camp.***
2. How will CVS Pharmacy get my child's prescriptions?  
***All prescriptions need to be faxed or called into the CVS Pharmacy in Pittsfield, MA by your child's doctor's office.***
3. What if my child takes their medication three times per day?  
***All medications will be packaged per dose. For example; if your child takes a medication three times per day we will have 3 packages, one for morning, afternoon and then one for evening/bed. Each will be labeled clearly to when the medication should be given.***
4. How soon does CVS/Pharmacy need my prescriptions before camp?  
***All prescriptions should arrive by June 1<sup>st</sup>, 2012.***
5. Can all prescriptions be faxed or called into the CVS in Pittsfield?  
***Most prescriptions can be faxed in or called in by a physician's office except for Schedule II medications. Those medications MUST be mailed to CVS in Pittsfield, MA. Please allow ample time for these to arrive.***
6. What is a Schedule II medication?  
***A Schedule II medication is a medication that requires a new hardcopy prescription each time the prescription is filled. These medications include Ritalin, Methylphenidate, Concerta, Adderall and many others.***
7. What if we already use CVS/Pharmacy in our home town?  
***If you already use a CVS in your home town please make sure to indicate that on your camper information sheet. We will need to know which medications your child will need so we can transfer them through the CVS system.***
8. What if my child is on an over the counter medication and needs to take that while they are at camp?  
***You may also use this service for over the counter medications. Items like daily vitamins, will also need a prescription faxed in or phoned in by the physician's office. If there is a particular vitamin that your child needs, please make sure to call the CVS in Pittsfield to make sure we can order the item if we don't already carry it.***
9. Can I bring medications from home to have packaged at another CVS/Pharmacy?  
***No, any medications that we package must come from our pharmacy in Pittsfield.***
10. What if I have questions or concerns about whether you have a medication that my child needs?  
***We are typically able to order medications that we don't carry within 24 hours. Please call our store in Pittsfield, MA at (413) 499-4624 if you have a particular concern and we will be very happy to help.***

Name of Camp: Camp Winadu  
Session Date: June 23<sup>rd</sup>– August 12<sup>th</sup>, 2012

CAMPER INFORMATION SHEET



107 West Street  
Pittsfield, MA 01201  
Phone: (413) 499-4624  
Fax: (413) 448-2583

Name of Camper \_\_\_\_\_

Date of Birth \_\_\_\_\_

Do you already use CVS/Pharmacy? YES OR NO

Address and/or phone number of the CVS you use: \_\_\_\_\_

\_\_\_\_\_

Name of Parents/Guardians \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone Number \_\_\_\_\_ Alternative Phone number \_\_\_\_\_

Allergies to any Medication \_\_\_\_\_

Medications expected from CVS/Pharmacy on day one of camp (please list below)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

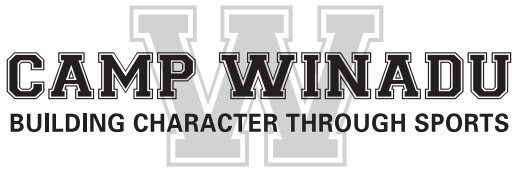
**\*\*PLEASE provide a photo copy of both sides of your PRESCRIPTION insurance card so we can make sure we are billing properly\*\***

Payment: Credit Card Type \_\_\_\_\_ Mastercard \_\_\_\_\_ Visa \_\_\_\_\_ American Express

Credit Card Number \_\_\_\_\_ Exp Date \_\_\_\_\_

Name on Credit Card \_\_\_\_\_

Please fax or mail the completed form to **CVS/pharmacy** in Pittsfield, MA.



PLEASE RETURN BY APRIL 1<sup>st</sup> TO:  
WINTER (September 1 - May 15)  
3 New King Street, White Plains, NY 10604  
p: 914-437-7200 f: 914-422-3635

SUMMER (May 16 - August 31)  
700 Churchill Street, Pittsfield, MA 01201  
p: 413-447-8900 / 800-494-6238  
f: 413-447-8905

# INSURANCE AND CREDIT CARD FORM

To be completed by parents for **ALL** campers. One per camper.

Please return this form by **April 1st**.

Camper's Name \_\_\_\_\_ Session \_\_\_\_\_

(Please Print or Type)

Dear Parents,

Insurance information (medical and prescription) is required to be on file for each camper along with credit card information. Camp Winadu will charge your credit card only if camp incurs incidental medical expenses for your child. We will share insurance and credit card information with CVS/pharmacy in Pittsfield, MA should your child require their service.

## INSURANCE INFORMATION

**I ATTACHED A COPY OF MY CHILD'S MEDICAL AND PRESCRIPTION INSURANCE CARDS (FRONT AND BACK) TO THIS FORM. (REQUIRED)**

If we do not have a copy of your insurance information at the time the prescription is filled or at the time of your child's appointment, the full amount will be charged to your credit card. You will be responsible for submitting a reimbursement claim to your insurance company for the charges.

Is your son covered by family medical insurance?  Yes  No

Insurance Carrier and Plan Name: \_\_\_\_\_

Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

Social Security Number of policy holder or Insurance ID Number: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

## CREDIT CARD INFORMATION

Visa  Mastercard

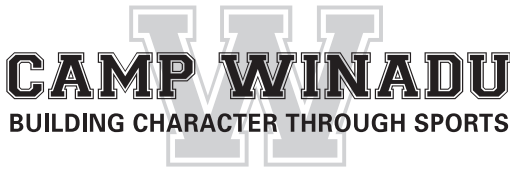
Cardholder's Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Card #: \_\_\_\_\_ Security code: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**If your child takes daily medications (prescription/non-prescription/vitamins), please complete the CVS/Pharmacy Medication Form enclosed by April 1st.**



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f: 413-447-8905

PERMISSION TO TREAT FORM 2012

To be completed by parents for ALL campers. One per camper.

Please return this form by April 1st.

Camper's Name \_\_\_\_\_

First, Last (Please Print)

Please read the following statement carefully before signing below.

The camper named above has permission to engage in all camp activities except as noted by me and/or an examining physician.

I understand that part of the camp experience involves activities and group living arrangements and interactions that come with certain risks and uncertainties beyond what my child may be used to dealing with at home. I am aware of these risks, and I am assuming them on behalf of my child. I realize that no environment is risk-free, and I have instructed my child on the importance of abiding by the Camp Winadu's rules.

It is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the camper named above, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

It is my intention that Camp Winadu be treated as acting "in loco parentis." I give permission to Camp Winadu to provide, seek, and consent to routine health care, administration of over the counter medications, administration of prescribed medications, and emergency treatment for my child, including, but not limited to x-rays, routine tests and treatment. I also give permission for the camp to arrange related transportation. In the event I cannot be reached in an emergency, I give permission to the physician selected by the camp to secure and administer treatment, including hospitalization.

I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. This signed form may be photocopied for trips out of camp.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_