Summer Camp Registration 2022
Morrow-Union-Delaware Counties

Please return **THIS** form to:
summercamp@bbbscentralohio.org

Camp Oty'Okwa
24799 Purcell Road
South Bloomingville, Ohio 43152
(740) 385-5279

Child's Information:

FIRST: ________________________ MIDDLE: ____________ LAST: ___________________________ Preferred Name: ____________

Age when at camp: ______ Birthday: ____/___/_______ Gender: _____ Grade, Fall 2022_______

Mailing Address: _________________________________ City_________________________ State ______ Zip________

Cell: (______) _____________________Other: (______) _________________County_____________________________

Email: _________________________________

Parent/Guardian Name____________________________________ Relationship to Child _______________________________

If the parent/guardian cannot be reached; persons to be notified in case of emergency:

Name	Relationship to Child	Preferred Phone	Secondary Phone
1.			
2.			

Cost to send your camper to Oty'Okwa is listed below. If your camper is a victim of crime or has experienced trauma, cost will be waived to attend camp. Has your camper experienced trauma? YES ☐ NO ☐ Scholarship applications are available to help cover the cost of camp for those families in need. If requesting a scholarship, how much are you requesting? _____________

2022 Camp Dates

Number of Days at Camp	Camps	Session Dates	First Day Check – In At Andrew's House	Last Day Pick-Up At Andrew's House	Cost of Camp
6	**Session 2** ADVENTURE CAMP AGES 6-21	Sunday, June 19 to Friday, June 24	8:00 am to 9:30 am	10:30 am	$450

Bus Transportation Options: (Please √ only one)

☐ **TO & FROM** Camp ☐ **TO** Camp *ONLY* ☐ **FROM** Camp *ONLY* ☐ Do **NOT** need transportation

Referring Agency: Please indicate the organization referring your camper and the Caseworker/Counselor (if any):

□ A BBBS Agency: ____

□ Other Agency OR School: ____

Caseworker/Counselor Name: ____

Caseworker/Counselor Email: ____

CAMPER HISTORY

In an effort to ensure your child is placed in the most appropriate cabin group, please provide us with the following information. All information will only be shared with Camp Staff.

Child's Name ______________________________________ Gender ______ Age ______

Child's Camp Experience:

This child has attended Camp Oty'Okwa Summer Camp. This will be the child's _________ year at Camp Oty'Okwa.

Has this child attended another camp before? _____ When and where? ____________________________________

Please comment on the child's previous camp experience: ____

____

Does the child need any special accommodations? Yes □ No □

If YES please explain: ____

Has the youth or family been involved with children's services and/or foster care? Yes □ No □

If YES please explain: ____

Has the youth or family been exposed to trauma of any kind? Yes □ No □

If YES please explain: ____

Please comment on the following regarding the child:

What would you like the child to accomplish while at camp?

____

Areas of success the child has had: ____

Does the child regularly use inappropriate language? Yes □ No □

Areas of positive self-esteem: ____

Camper's talents, strengths, and abilities: ____

Anything else that we should know about the child (behavior management, fear management, recent experience, etc.):

____

Child's Educational Background:

Child's School: ____ Current Grade: _______

□ Regular classes □ Regular classes with tutoring □ Self-contained Special Class

Please indicate which of the following information pertains to this child (check all areas that apply)

Child's Characteristics:

___Immature	___Insensitive	___Teases	___Physically aggressive
___Mature	___Demanding	___Calm	___Works well with others
___Self-reliant	___Confident	___Outgoing	___Likes to be alone
___Shy / withdrawn	___Friendly	___Helpless	___Resistant to authority
___ Inattentive	___Disruptive	___Sensitive	___Feels inadequate
___Complains	___Disobedient	___Moody	___Needs a lot of attention
___Non-Conforming	___Obedient	___Temper	___Needs encouragement
___Physically Small for age	___Physically big for age	___Outbursts	___Leader

Concerns and assistance that camper may need:

___Vision	___Mobility	___Brushing teeth	___Toileting	___Dressing	___Homesickness
___Hearing	___Medication	___Religious Restrictions	___Bedwetting	___Allergies	___Other______________

CAMP OTY'OKWA LIABILITY RELEASE AND CONSENT

I, ____________________________ , **(parent/legal guardian's name)** am the parent and/or legal guardian of __________________________, **(camper's name)**, a minor and I agree to permit him or her to attend and participate in the Big Brothers Big Sisters of Central Ohio, Camp Oty'Okwa Summer Camp.

I understand that certain risks and dangers may exist in my child's attendance and participation in Camp Oty'Okwa and that my child's attendance and participation in Camp Oty'Okwa is conditioned upon my agreement to release any claims of liability, including, but not limited to any claims for property loss or personal injury to child/ward. Therefore, in exchange for the opportunity of my child/ward to attend and participate in Camp Oty'Okwa, I hereby release Big Brothers Big Sisters of Central Ohio, its board, officers, staff, employees, and volunteers from all claims which I or my child/ward may have for liability or legal responsibility for any damage or loss of any kind, including, without limitation, claims for personal injury, property damage or loss, and economic loss occurring during or resulting from my child's attendance and/or participation and/or travel to or from Camp Oty'Okwa which is caused by negligence, breach of contract, strict liability, or otherwise.

I give full permission for my child/ward to participate in all phases of activities. I have read the camp information and understand and agree to cooperate with all regulations. I also understand that in case of late cancellation, the registration fee will not be refunded. I give my permission to allow Camp Oty'Okwa and Big Brothers Big Sisters of Central Ohio, to use and photographs taken of my child/ward or their designee to promote/advertise Camp Oty'Okwa and Big Brothers Big Sisters of Central Ohio in paper publications, signage, television, websites, blogs, and social media sites.

Parent/Guardian Signature___________________________________ ***Date***____________________

We use the following information for applying to grants that help fund our summer camp program so we can continue to offer low cost summer programs. All information will be kept confidential. You are not required to answer the following questions**.**

*** **Circle the TOTAL Household Income in one of the columns below**: ***

REDUCED INCOME ELIGIBILITY GUIDELINES – 185% Guidelines
Effective from July 1, 2020 to June 30, 2021
Households with incomes less than or equal to the reduced-price values are eligible for free or reduced-price meal benefits.

HOUSEHOLD SIZE	ANNUAL	MONTH	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
1	23,606	1,968	984	908	454
2	31,894	2,658	1,329	1,227	614
3	40,182	3,349	1,675	1,546	773
4	48,470	4,040	2,020	1,865	933
5	56,758	4,730	2,365	2,183	1,092
6	65,046	5,421	2,711	2,502	1,251
7	73,334	6,112	3,056	2,821	1,411
8	81,622	6,802	3,401	3,140	1,570
For each add'l family member, add	8,288	691	346	319	160

Does your child receive reduced or free lunches at school?

___Yes ___No

Racial/Ethnic History: If you choose, please indicate (√) one or more of the following identities:

□ Black or African American
□ White or Caucasian
□ Hispanic or Latino
□ Asian
□ American Indian or Alaskan Native
□ Native Hawaiian or Pacific Islander
□ Multi-Racial _______________________
□ Other_______________________

Monthly household Income ________ or **Annual Income** ________ **# people in your household** _____

EITHER Part 1 OR Part 2 MUST be completed, signed & dated:

Ohio Summer Food Service Program 2021 Income Eligibility Application

INSTRUCTIONS: Part 1 of this form is to be used only for children receiving Ohio Works First (OWF) or for children living in a household receiving Supplemental Nutrition Assistance Program (SNAP, food assistance) benefits. Complete Part 2 only for children not receiving OWF or SNAP benefits. Please complete the applicable section of the form. An adult signature is required to submit both sections. If you need more space, please attach a separate sheet.

*** PRINT CHILD INFORMATION WHEN COMPLETING EITHER PART 1 OR PART 2:**
Enter name of **ONLY** those children participating in the Summer Food Service Program (SFSP).

1.		3.	
2.		4.	

PART 1 - FOR CHILDREN RECEIVING SNAP (FOOD ASSISTANCE) OR OHIO WORKS FIRST (OWF)

________YES, I received SNAP (Food Assistance) or OWF benefits for the child(ren) listed above this month and request meal benefits.
My SNAP or OWF number is:

________________________________* OHIO BENEFITS (SNAP) BENEFIT NUMBER (7-digit number) **OR (THIS IS NOT YOUR CARD NUMBER)**
________________________________* OHIO WORKS FIRST NUMBER **OR**
________________________________* FDPIR Identification Number (Food Distribution Program on Indian Reservations)

PENALTIES FOR MISREPRESENTATION: I certify that all the above information is true and correct and that the SNAP and OWF numbers are correctly reported. I understand that this information is being given for receipt of federal funds; that program officials may verify the information on the application; and that deliberate misrepresentation of this information may subject me to prosecution under applicable state and federal laws.

____*
SIGNATURE OF ADULT HOUSEHOLD MEMBER ADDRESS DAYTIME PHONE DATE

PART 2 - FOR CHILDREN NOT RECEIVING SNAP OR OWF **BENEFITS**

HOUSEHOLD MEMBERS AND MONTHLY INCOME: List the names of all individuals living in your household including yourself, all related and non- related individuals and children. Include children listed above. List all income received last month on the same line with the person who received it. List each amount under the correct title. You must list gross income **BEFORE** deductions, taxes, social security, etc. To determine monthly income, if income is received every week, multiply the total gross income x 4.33; every two weeks, multiply the total gross income x 2.15; twice a month, multiply the total gross income x 2; or once a year, divide the total gross income by 12.

*** HOUSEHOLD MEMBERS**	***INCOME BY SOURCE**			
LIST ALL HOUSEHOLD MEMBERS (LAST NAME, FIRST NAME)	MONTHLY EARNINGS FROM WORK BEFORE DEDUCTIONS	MONTHLY WELFARE, CHILD SUPPORT, ALIMONY	MONTHLY PENSIONS, RETIREMENT, SOCIAL SECURITY	ALL OTHER MONTHLY INCOME
1.				
2.				
3.				
4.				
5.				
6.				

FOSTER CHILD: Complete a separate application for each foster child. In certain cases, meals served to foster children may be reimbursed regardless of the foster family's income. If you are applying for foster children living with you, complete the application as if for a family of one. List the child's name and monthly personal use income or enter "0" if the child has no personal use income. An adult signature is required. Personal Use Income $________________

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for receipt of federal funds; that program officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

____ **LAST 4 DIGITS OF SOCIAL SECURITY #**________________
*SIGNATURE OF ADULT HOUSEHOLD MEMBER ***SOCIAL SECURITY NUMBER** OF ADULT HOUSEHOLD MEMBER
(Write “None” if adult signer does not have a SSN)

____
HOME ADDRESS ZIP CODE DAYTIME PHONE DATE

Total Household Monthly Income **FOR SPONSOR USE ONLY** **Signature of Authorized Official** **Date**

$__________ELIGIBILITY DETERMINATION **_______APPROVED___________DENIED** ________________________________

Camper Health History

Please return this form to:

Camp Oty'Okwa
24799 Purcell Rd. South Bloomingville, OH 43152
Phone: 740-385-5279 Fax: 740-385-3962

Camper's Name
LAST_______________ **FIRST** (preferred)_______________ Middle _______

Gender __________ Current Grade ______ **Birth Date** __________ **Age when at camp** ______

Home Address: ______________________________

____

Custodial Parent/Guardian: ______________________ Relationship: __________

Preferred Phones: (_____) _______ - ____________ (_____) _______ - ____________

Second Emergency Contact: ______________________ Relationship: __________

Preferred Phones: (_____) _______ - ____________ (_____) _______ - ____________

Allergies:

☐ No Known Allergies
☐ This Camper is Allergic to: ☐ Food ☐ Medicine ☐ Environment

Please describe below what camper is allergic to and the reactions seen:

____

____

Diet/Nutrition:

☐ This Camper eats a regular diet.
☐ This Camper eats a regular vegetarian diet.
☐ This Camper has special food needs. Please describe below:

____

____

Restrictions:

☐ I have reviewed the program and activites of the camp and feel the camper can pariticpate without restricitions.
☐ I have reviewed the program and activities of the camp and feel the camper can paritipate with the following restricitons or adapations. Please describe below:

____

____

Parent/Guardian Authorization for Health Care:

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.

____

PRINT Parent/Guardian Name: FIRST **MIDDLE** **LAST** **Parent/Guardian Date of Birth**

______________________________ __________ __________

SIGNATURE of Custodial Parent/Guardian **Date** **Relationship to Camper**

*If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Camper Name:

Session:

Cabin Assignment:

Medical Insurance Information:

This camper is covered by family medical/hospital insurance: ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company: ________________________________ Insurance Company Phone Number: (______) __________________

Group Number: ____________________________________ Plan/Policy Number: _________________________

Subscriber: ____

Prescription Insurance Information:

This camper is covered by family prescription insurance: ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company: ________________________________ Insurance Company Phone Number: (______) __________________

Rx BIN Number: ___________________________________ Rx PCN Number: _________________________

Subscriber: ____

Immunization History: (Only check ONE box)

☐ Camper has been fully immunized and all shots required to attend school are up to date including a tetanus shot on _____/______.
Month/Year

☐ Camper has NOT been fully immunized and I understand and accept the risks to child from not being fully immunized.

______________________________________ ______________ ____________________

Signature of Custodial Parent/Guardian **Date** **Relationship to Camper**

Medication:

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ **This person takes NO medications on a routine basis.**

☐ **This person takes medications as follows:**

Med #1 ___________________________ Dosage ___________ Specific times taken each day ______________________________

Reason for taking ____

Med #2 ___________________________ Dosage ___________ Specific times taken each day ______________________________

Reason for taking ____

Med #3 ___________________________ Dosage ___________ Specific times taken each day ______________________________

Reason for taking ____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer:

____

____

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)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)

Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

1. Ever been hospitalized? ☐ Yes ☐ No
2. Ever had surgery? ☐ Yes ☐ No
3. Have recurrent/chronic illnesses? ☐ Yes ☐ No
4. Had a recent infectious disease? ☐ Yes ☐ No
5. Had a recent injury? ☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath? ☐ Yes ☐ No
7. Have diabetes? ☐ Yes ☐ No
8. Had seizures? ☐ Yes ☐ No
9. Had headaches? ☐ Yes ☐ No
10. Wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No
11. Had fainting or dizziness? ☐ Yes ☐ No
12. Passes out/had chest pain during exercise? ☐ Yes ☐ No
13. Had mononucleosis ("mono") during the past 12 months? ☐ Yes ☐ No
14. If female, have problems with periods/menstruation? ☐ Yes ☐ No
15. Have problems with falling asleep/sleepwalking? ☐ Yes ☐ No
16. Ever had back/joint problems? ☐ Yes ☐ No
17. Have a history of bedwetting? ☐ Yes ☐ No
18. Have problems with diarrhea/constipation? ☐ Yes ☐ No
19. Have any skin problems? ☐ Yes ☐ No
20. Traveled outside the country in the past 9 months? ☐ Yes ☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

____

____

____

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life? ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

____

____

____

Health-Care Providers:

Name of camper's primary doctor(s): ______________________ Phone: (______) ____________

Name of dentist(s): ______________________ Phone: (______) ____________

Name of orthodontist(s): ______________________ Phone: (______) ____________

What Have We Forgotten to Ask? Please provide in the space below any additional information about the camper's health that you think important or may affect camper's ability to fully participate in the camp program. Attach additional information if needed.

____

____

____

____

____

Parents/Guardians: STOP here. The rest of this form is completed when the camper arrives at camp. Keep a copy for your records.

Cabin Assignment:

Session:

Camper Name:

Individual Health Record (For Camp Use Only)

Camper Name: ______________________________ **Camper Date of Birth:**__________________

Initial Screening **Date/Time:** ____________________ **Initials:** _________

☐ **Screening** has been conducted according to camp protocol and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival? ☐ No ☐ Yes as noted below

B. History of exposure to communicable disease? ☐ No ☐ Yes as noted below

C. Are you experiencing a new cough (not related to allergies)? ☐ No ☐ Yes as noted below

D. Are you experiencing shortness of breath or difficulty breathing? ☐ No ☐ Yes as noted below

E. Are you experiencing shortness of breath or difficulty breathing? ☐ No ☐ Yes as noted below

F. Are you experiencing two or more of the following symptoms? ☐ No ☐ Yes as noted below

Chills - Repeated Shaking - Muscle Pain

G. Have you or a household member: ☐ No ☐ Yes as noted below

Been instructed by a medical professional to isolate for potential coronavirus, with or without being tested?

Had prolonged close contact* with someone who has tested positive for the coronavirus?

Traveled to one of the states listed as part of Ohio's travel advisory within the last 14 days?

H. Additions or corrections to information on this health history? ☐ No ☐ Yes as noted below

I. Medication given to health-care staff? ☐ No ☐ Yes as noted below

J. Any signs/symptoms of head lice? ☐ No ☐ Yes as noted below

If camper experiences any symptoms of coronavirus prior to attendance, they will not be permitted to attend camp. If any symptoms of coronavirus occur at camp, the camper will be monitor and a decision to send the camper home will be made. The camp staff will work with the parents/ guardians to arrange for appropriate transportation.

Provider notes: (date/time/initial all entries)

____

____

____

____

____

____

____

____

Exit Note: Check one of the following:

☐ Left camp this day with no reported illness or injury symptoms.

☐ Left camp this day with the following problem/concern:

____

____

This person was told about the problem and instructed about follow-up as noted above: ______________________

Date/Time: ____________________ Initials: _____________