ROCKLAND FENCERS CLUB

Registration Form

Camper's name: _____

Date of birth: _____

Parent's name: _____

Phone number: _____

Email address: _____

Address: _____

Emergency contact: _____

Emergency Phone number: _____

Primary club: _____

Weapon (circle one): Epee Foil

Years of experience: _____

Coach: _____

USFA membership number: _____

How did you hear about this camp? _____

ROCKLAND FENCERS CLUB

Payment information and authorization

Please check one option:

- ❏ Single room: $1600
- ❏ Double room: $1400 Roommate Request:_____

$500 non refundable deposit fee due at registration. Full payment due by July 1st 2024. $150 late fee will apply for registrations made after 5/31.

For additional direct family members a $100 family discount applies. **(if we already have your payment information please ignore this section)**

Name:_____

Credit card number: _____

Expiration: _____

CCV: _____

ZIP: _____

Payment schedule (date for 2nd payment): _____

I _____ authorize Rockland Fencers Club LLC to charge my card based on the payment schedule above.

Signature: _____ **Date:** _____

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Primary health insurance and physician information

Primary health insurance provider: _____

Policy number: _____

Phone number: _____

Primary physician's name: _____

Primary physician's phone number: _____

Primary physician's email: _____

Physician Examination and Immunization Form

(school forms accepted if dated within 36 month prior to arrival date)

Name: _____ DOB: _____
General appearance:_____ Height: _____ Weight:_____ Eyes: _____
Blood pressure:_____ Hgb test: _____ Urinalysis (date): _____
Posture/spine:_____ Vision: _____Throath and tonsils:_____
Lungs: _____Skin: _____ Nose: _____ Teeth:_____
Abdomen: _____ Hernia: _____ Genitalia: _____
Neurological findings: _____ Abnormal findings: _____
Alergies:_____

Recommendations and restrictions while in camp (diet, medicines, activities):_____
_____
_____

General appraisal: _____
_____

Immunization history (dates):
DTaP/DTP/TD: _____
Polio: _____
PCV: _____

MCV: _____
MNR: _____
Haemophilus Influenzae type B: _____
Hepatitis A: _____
Hepatitis B: _____
Varicella: _____
Other: _____

I _____ have examined the person above. Reviewed his/her health history and in my opinion he/she physically able to participate in a fencing training camp.

Physician's signature: _____ **Phone number:**_____

Date: _____

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Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____
Date of Birth____/____/____Today's Date____/____/____

Address of Child
_____Town_____

Medication Name/Generic Name of Drug_____
Controlled Drug? YES / NO

Condition for which drug is being administered:
_____

Specific Instructions for Medication Administration
_____

Dosage_____Method/Route_____

Time of Administration _____ If PRN,frequency_____

Medication Start Date: _____/_____/_____ End Date: _____/_____/_____

Relevant Side Effects of Medication_____

Explain any allergies, reaction to/negative interaction with food or drugs:
_____

Plan of Management for Side Effects:

_____

Prescriber's Name/Title _____ Phone Number (_____) _____

Prescriber's Address _____

Prescriber's Signature _____ Date _____/_____/_____

Parent/Guardian Authorization:

- ❏ I request that medication be administered to my child/student as described and directed above.
- ❏ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)
- ❏ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____

Relationship_____ Date ____/____/____

Parent /Guardian's Address _____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____
Cell Phone # (_____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL:

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: YES / NO

Prescriber's signature: _____ Date:_____

Parent/Guardian authorization for self-administration: YES / NO

Parent/Guardian's signature:_____ Date:_____

****

Today's Date: _____

Individual Receiving Written Authorization and Medication: _____

Title/Position _____ Signature _____

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

Over-the-counter medications authorization form

Check the medicine list and sign below if you would like to give camp nurses/health supervisors permission to administer any of the below medications on an as needed basis at their discretion.

The dosage will be according to guidelines listed on the container.

Acetaminophen (Tylenol) for headaches, muscle aches, or fever Y / N

Ibuprofen (Advil/Motrin) for i.e.headaches, muscle aches, fever, menstrual cramps Y / N

Benadryl (only in case of hives/serious allergic reactions) Y / N

Other: _____

I _____ hereby authorize the Rockland Fencers Club Summer Camp to administer the medications circled Y above, to my child.

Parent/Guardian Signature: _____ Date: _____

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HEALTHCARE PROVIDER'S ORDERS FOR ALLERGY EMERGENCY TREATMENT

Student's name: _____

The above student is allergic to: _____

Asthmatic: Yes No

MEDICATIONS

PLEASE NOTE: The Camp Nurse by law may administer any medication with physician's orders and parental consent, but trained non-medical designees, who may give emergency treatment in the Camp Nurse's absence, are NOT permitted by law to administer any medications other than epinephrine via auto-injector mechanism.

EPINEPHRINE: EpiPen EpiPen Jr. Other _____

Camp Nurse or designee: Give epinephrine for the following checked symptoms:

- ❑ Contact with allergen, but no symptoms
- ❑ Skin – hives, itchy rash, extremity swelling
- ❑ Lips – itching, tingling, burning, or swelling of lips
- ❑ Head/neck – swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat
- ❑ Gut – abdominal cramps, nausea, vomiting, diarrhea
- ❑ Lungs – repetitive cough, wheezing, shortness of breath
- ❑ Heart – thready pulse, low blood pressure, fainting, pale or bluish skin
- ❑ Other _____

After giving epinephrine, call 911, parent, and health care provider.

Parent's name: _____ Phone: _____

Health care provider: _____ Phone: _____

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ANTIHISTAMINE: Medication _____ Dose _____

School Nurse only: Give antihistamine for the following checked symptoms:

- ❑ Contact with allergen, but no symptoms
- ❑ Skin – hives, itchy rash, extremity swelling
- ❑ Lips – itching, tingling, burning, or swelling of lips
- ❑ Head/neck – swelling of tongue, mouth, or throat, hoarseness, hacking cough, tightening of throat
- ❑ Gut – abdominal cramps, nausea, vomiting, diarrhea
- ❑ Lungs – repetitive cough, wheezing, shortness of breath
- ❑ Heart – thready pulse, low blood pressure, fainting, pale or bluish skin
- ❑ Other: _____

OTHER INSTRUCTIONS: _____

- ❑ This student has been trained and is authorized to **self-administer** the following medication(s) named above. epinephrine – single dose unit, antihistamine – single dose _____mg

- ❑ This student is not authorized to self-administer the medication(s) named above.

Healthcare Provider's signature _____ Date _____

Healthcare Provider's Stamp_____

Parents signature_____ Date _____

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Release and waiver of liability

I _____ understand that participating in the camp involving risk of injury. I understand that in any sport, such as the sport involved at this camp, an athletic participant can be seriously injured. I am aware that the dangers and risks of my child's playing or participating in the above sport include, but are not limited to, falls, contact or collisions with other participants, equipment and facilities, and the effects of weather, including high heat and humidity. I have certified to the organizers, by my signature below, that my child is in good health and physical condition and sufficiently able to participate in the camp. I have advised the organizers of any limitations on my child's activities for medical reasons in writing. I hereby agree on behalf of myself, my family members and my child/ward to assume all such risks and, further, to waive, release, discharge and hold harmless the Rockland Fencers Club LLC, its coaches and their employees from any and all liability, actions, causes of actions, claims or demands for personal injury and/or illness of any kind or nature, and any other claims whatsoever arising out of, or in any way connected with, my child's playing and participating in the camp. I fully understand that the camp is not providing 24/7 personal supervision and the participant will be held responsible for all property damage resulting from unauthorized use or improper behavior. This Release and Waiver extends to all claims of every kind or nature whatsoever, foreseen or unforeseen, known or unknown.

I hereby consent to permit the coach and staff working at the Rockland Fencers Club LLC Summer Camp, to provide emergency first-aid or medical treatment for my child according to their best judgment, in the event he/she suffers an injury or illness while participating in the camp or on the camp premises.

The camp is not responsible for personal items that are lost, stolen or damaged. I also understand that pictures taken at camp may be used in any promotional materials.

Camper's Name _____

Signature of Parent or Legal Guardian _____ Date_____

ROCKLAND FENCERS CLUB

Summer Camps

at Avon Old Farms School

Stolen Goods Policy

Due to the nature of Avon's prep school environment, dormitory room doors do not have locks. The external doors to the dormitories automatically lock from 11:30 pm - 6:00 am. The campus tries to foster a sense of community and safety, where everyone's belongings are respected. Unfortunately, petty theft can take place. To combat this, each room has a lockable closet or desk drawer for valuables. It is recommended that campers bring a combination lock or a keyed lock from home for the duration of their stay at camp.

Summer Camps at Avon Old Farms School and Avon Old Farms School are not responsible for lost or stolen items.

Disclaimer and Parental Consent

I, the undersigned, understand that the Summer Camps at Avon Old Farms School and Avon Old Farms School take no responsibility for any personal property lost, stolen, or otherwise missing by any camper.

Parent/Guardian Signature:_____ **Date:** _____