

Jewish Community Center of the North Shore

**Summer at the J: 2023 – CAMPER FORMS PACKET**



**All forms must be  
returned by June 1, 2023**

**CAMPER REGISTRATION IS NOT COMPLETE UNTIL  
ALL FORMS HAVE BEEN PROCESSED**

Please send or scan and email forms directly to Camp Directors:

KinderCamp: [hgreenberg@jccns.com](mailto:hgreenberg@jccns.com)

Camp Simchah: [hgravelese@jccns.com](mailto:hgravelese@jccns.com)

**JCCNS  
Summer at the J  
4 Community Road  
Marblehead, MA 01945**

*Questions? Please contact:*

KinderCamp Director: Heather Greenberg – [hgreenberg@jccns.com](mailto:hgreenberg@jccns.com)

Camp Simchah Director: Heather Gravelese – [hgravelese@jccns.com](mailto:hgravelese@jccns.com)

Camp Controller: Scott Kaplan – [skaplan@jccns.com](mailto:skaplan@jccns.com)

## CONFIDENTIAL CAMPER INFORMATION

This form is required and must be completed by a parent/guardian for each camper and/or LIT. The information in this form is kept confidential. Its sole purpose is to help our camp staff to better understand your child.

Camper Name: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_\_\_

Preferred Name/Nickname: \_\_\_\_\_ Gender: \_\_\_\_\_

School/District: \_\_\_\_\_ Grade entering Fall 2023: \_\_\_\_\_

Street Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Town/City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**\*Please attach a recent photo of your child to be kept in their file.\***

Parent/Guardian 1 Name: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Guardian 2 Name: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Guardians' Marital Status: \_\_\_\_\_ Camper lives with: \_\_\_\_\_

Siblings:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade entering 2023 (if applicable): \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade entering 2023 (if applicable): \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade entering 2023 (if applicable): \_\_\_\_\_

1. Has your child attended any camp before? If yes, please list the name of the camp and how many years.
2. What did your child enjoy most/least about camp (activities, staff, special events, etc.)?

**CONFIDENTIAL INFORMATION CONTINUED... (attach separate page if needed)**

3. What is your child looking forward to most about this summer at camp?
4. Is there anything your child is nervous or not looking forward to at camp this summer?
5. What are your child's favorite interests and hobbies?
6. Are there any specific emotional triggers for your child? Please explain.
7. What are your child's abilities and comfort level regarding swimming?
8. Please list all that apply for your child:
  - a. Fears:
  - b. Restrictions (physical, sensory, emotional, etc):
  - c. Allergies:
  - d. Health problems:
9. Does your child have an IEP, 504b, individual health plan, or support services? If yes, please register through our Inclusion Program to ensure proper support at camp.  

\_\_\_\_\_ **yes\*** \_\_\_\_\_ **no**

*\*Any child on an IEP, 504b, who has a medical or developmental diagnosis or who receives specialized services should register through our Inclusion Program. Once camp begins, if it is determined that your child requires additional support at camp, the Camp Leadership Team may pause participation and your child will be put on a waitlist until support can be provided.*

Please explain:
10. Are there any special issues the camp should be aware of in order to help your child enjoy his/her summer experience? (Recent family move, death, new school, birth, separation, divorce.) If so, please describe the situation.

**CONFIDENTIAL INFORMATION CONTINUED... (please attach separate page, if needed)**

11. How does your child establish new relationships with:

a. **peers:** \_\_\_\_\_ *with ease*      \_\_\_\_\_ *slowly*      \_\_\_\_\_ *with difficulty*  
**please explain:**

b. **adults:** \_\_\_\_\_ *with ease*      \_\_\_\_\_ *slowly*      \_\_\_\_\_ *with difficulty*  
**please explain:**

12. Is there any additional information about your child’s social interactions that you’d like us to know:

13. How does your child follow directions in a group setting:

\_\_\_\_\_ *with ease*      \_\_\_\_\_ *slowly*      \_\_\_\_\_ *with difficulty*  
**please explain:**

14. How does your child transition from one activity to the next:

\_\_\_\_\_ *with ease*      \_\_\_\_\_ *slowly*      \_\_\_\_\_ *with difficulty*  
**please explain:**

15. Is there anything else that would help us get to know your child better?

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Parent/Guardian Name**

# HEALTH HISTORY

(PLEASE PRINT)

NAME \_\_\_\_\_  
*Last*
*First*
*M.I.*

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

**\*Please check each box below**

Have you had? (Check box)	No	Yes	Have you had? (Check box)	No	Yes
Recurrent Headache			Asthma		
Eye Problem			Epilepsy/Seizures		
Ear Problem			Dizziness/Fainting with Exercise		
Nose Problem			Head Injury/Concussion		
Throat Problem			Bone/Joint Injuries		
Thyroid Disorder			Stomach/Intestinal Problems		
Heart Murmur/Heart Disease			Diabetes		
Heart Palpitations			Eating Disorder		
High/Low Blood Pressure			ADD/ADHD		
Anemia/Sickle Cell			Chicken Pox/Immunization		
Bleeding Disorders: Hemophilia/Other			Mononucleosis		
Hepatitis			Alcohol Abuse		
Kidney/Bladder Disorders			Drug Abuse		
Pneumonia/Bronchitis			Sexual Assault/Violence		
Tuberculosis			Emotional Problems-Specify Below:		
Seasonal Allergies/Hay Fever					
Surgeries:					
Hospitalizations:					
<b>Allergies:</b>					
<b>Medication Allergies:</b>					
<b>Medication currently taking:</b>					

**Any other disease, illness, past surgeries, permanent disabilities, or explanations of any marked concerns from the list above?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Are you currently being treated by a health care professional? If yes, explain** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# PERMISSIONS

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Permission Slip to RIDE IN CAMP VEHICLES

I give permission to have my child, \_\_\_\_\_, ride in camp vehicles for transport to and from camp, and in private vehicles in case of emergency evacuation.

## Permission Slip for HEAD LICE CHECK

I do \_\_\_\_\_ do not \_\_\_\_\_ give permission to have my child's, \_\_\_\_\_, head checked for lice.

## Permission Slip for SUNSCREEN USE AT CAMP

I do \_\_\_\_\_ do not \_\_\_\_\_ give permission for my child's counselor (or if appropriate, my child) to apply the following:

SUNSCREEN \_\_\_\_\_  
(Brand name or ANY)

I do \_\_\_\_\_ do not \_\_\_\_\_ give permission for my child's counselor (or if appropriate, my child) to apply ANY BRAND of sunscreen if my child runs out of the above brand.

Special instructions: \_\_\_\_\_

*Please label any containers of sunscreen with your child's name.*

## Permission Slip for HAND SANITIZER

When handwashing is not available: I do \_\_\_\_\_ do not \_\_\_\_\_ give permission to have my child to use hand sanitizer

## Permission slip for INSECT REPELLENT USE

I do \_\_\_\_\_ do not \_\_\_\_\_ give permission to have my child's counselor (or if appropriate, my child) to apply the following:

INSECT REPELLENT: \_\_\_\_\_  
(Brand name or ANY)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**TO BE COMPLETED FOR CAMPERS WHO STAY UNTIL 4:00pm**

Dear *Summer at the J* Parent,

I would like to inform you that the outdoor pool will be open to our membership during the time that your child is in their afternoon swim and/or enrichment. We are ensuring that the following conditions be met to keep campers safe, comfortable, and in a closely contained group:

- 1) All lifeguards responsible for the afternoon swimmers will be regular camp lifeguards.
- 2) After the afternoon swim, all campers will change in a closed room inaccessible to the general membership.

Please sign and return the bottom of this form indicating your receipt of this note and acceptance of these conditions.

Thank you for your understanding. Please let us know if you have any questions or concerns surrounding afternoon swim.

Sincerely,

Heather Greenberg  
KinderCamp Director  
[hgreenberg@jccns.com](mailto:hgreenberg@jccns.com)  
857-285-7920 - Office  
857-285-7968 - Campsite

Heather Gravelese  
Camp Simchah Director  
[hgravelese@jccns.com](mailto:hgravelese@jccns.com)  
857-285-7923

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\_\_\_ I have received the letter informing me that the afternoon swim will occur while the pool is open to JCCNS members and accept the conditions as outlined.

\_\_\_\_\_  
Name of camper(s)

\_\_\_\_\_  
DOB(s)

\_\_\_\_\_  
Signature of parent

\_\_\_\_\_  
date

# EMERGENCY CARE FORM

Camper Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Parent/Guardian 1 Name: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent/Guardian 2 Name: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**ADDITIONAL EMERGENCY CONTACT** \_\_\_\_\_ **PHONE** \_\_\_\_\_

Relationship: \_\_\_\_\_

**ADDITIONAL EMERGENCY CONTACT** \_\_\_\_\_ **PHONE** \_\_\_\_\_

Relationship: \_\_\_\_\_

HEALTH INSURANCE COMPANY: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_

Physician's Name & Phone \_\_\_\_\_

I understand that this release will only be used if I/we cannot be reached by the camp.

I give permission to have my child, \_\_\_\_\_, taken to the nearest physician or hospital in case of emergency and to have anesthesia administered if necessary and/or to have a qualified person administer first aid, if necessary.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**



# CHILD RELEASE FORM

Camper Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

I give permission for my child to be picked up from camp by any of the following adults (in addition to the parent/guardians listed on page 1) during this camp season:

1. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Relationship: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Relationship: \_\_\_\_\_

3. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Relationship: \_\_\_\_\_

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

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## **Permission Slip to WALK HOME**

(only for *Simchah* Campers/LITs who are 10 years of age and older)

I give my child, \_\_\_\_\_, permission to WALK home from camp.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

# Authorization to Administer Medication to a Camper

(completed by parent/guardian)

Camper and Parent/Guardian Information	
Camper's Name:	
Age:	Food/Drug Allergies:
Diagnosis (at parent/guardian discretion):	
Parent/Guardian's Name:	
Home Phone:	Business Phone:
Emergency Telephone:	
Licensed Prescriber Information	
Name of Licensed Prescriber:	
Business Phone:	Emergency Phone:
Medication Information 1	
Name of Medication:	
Dose given at camp:	Route of Administration:
Frequency:	Date Ordered:
Duration of Order:	Quantity Received:
Expiration date of Medication Received:	
Special Storage Requirements:	
Special Directions (e.g., on empty stomach/with water):	
Special Precautions:	
Possible Side Effects/Adverse Reactions:	
Other medications (at parent/guardian discretion):	
Location where medication administration will occur:	
Medication Information 2	
Name of Medication:	
Dose given at camp:	Route of Administration:
Frequency:	Date Ordered:

Duration of Order:	Quantity Received:
Expiration date of Medication Received:	
Special Storage Requirements:	
Special Directions (e.g., on empty stomach/with water):	
Special Precautions:	
Possible Side Effects/Adverse Reactions:	
Other medications (at parent/guardian discretion):	
Location where medication administration will occur:	
<b>Authorization Information</b>	
I hereby authorize the health care consultant or properly trained health care supervisor at _____ (name of camp) to administer, to my child, _____ the medication(s) listed above, in accordance with 105 CMR _____ (name of camper) 430.160(C) and 105 CMR 430.160(D) [see below].	
<b>If above listed medication includes epinephrine injection system:</b>	
I hereby authorize my child to <u>self-administer</u> , with approval of the health care consultant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
I hereby authorize an employee that has received training in allergy awareness and epinephrine administration to administer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
<b>If above listed medication includes insulin for diabetic management:</b>	
I hereby authorize my child to <u>self-administer</u> , with approval of the health care consultant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
Signature of Parent/Guardian:	Date:

\*\* **Health Care Consultant** at a recreational camp is a Massachusetts licensed physician, certified nurse practitioner, or a physician assistant with documented pediatric training. **Health Care Supervisor** is a staff person of a recreational camp for children who is 18 years old or older; is responsible for the day to day operation of the health program or component, and is a Massachusetts licensed physician, physician assistant, certified nurse practitioner, registered nurse, licensed practical nurse, or other person specially trained in first aid.

## 105 CMR 430 References

**105 CMR 430.160(A):** Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use. (M.G.L. c. 94C § 21).

**105 CMR 430.160(C):** Medication shall only be administered by the health care supervisor or by a licensed health care professional authorized to administer prescription medications. If the health care supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. The health care consultant shall acknowledge in writing a list of all medications administered at the camp. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.

**105 CMR 430.160(D):** A written policy for the administration of medications at the camp shall identify the individuals who will administer medications. This policy shall:

- (1) List individuals at the camp authorized by scope of practice (such as licensed nurses) to administer medications; and/or other individuals qualified as health care supervisors who are properly trained or instructed, and designated to administer oral or topical medications by the health care consultant.
- (2) Require health care supervisors designated to administer prescription medications to be trained or instructed by the health care consultant to administer oral or topical medications.
- (3) Document the circumstances in which a camper, Health Care Supervisor, or Other Employee may administer epinephrine injections. A camper prescribed an epinephrine auto-injector for a known allergy or pre-existing medical condition may:
  - a) Self-administer and carry an epinephrine auto-injector with him or her at all times for the purposes of self-administration if:
    - 1) the camper is capable of self-administration; and
    - 2) the health care consultant and camper's parent/guardian have given written approval
  - b) Receive an epinephrine auto-injection by someone other than the Health Care Consultant or person who may give injections within their scope of practice if:
    - 1) the health care consultant and camper's parent/guardian have given written approval; and
    - 2) the health care supervisor or employee has completed a training developed by the camp's health care consultant in accordance with the requirements in 105 CMR 430.160.
- (4) Document the circumstances in which a camper may self-administer insulin injections. If a diabetic child requires his or her blood sugar be monitored, or requires insulin injections, and the parent or guardian and the camp health care consultant give written approval, the camper, who is capable, may be allowed to self-monitor and/or self-inject himself or herself. Blood monitoring activities such as insulin pump calibration, etc. and self-injection must take place in the presence of the properly trained health care supervisor who may support the child's process of self-administration.

**105 CMR 430.160(F):** The camp shall dispose of any hypodermic needles and syringes or any other medical waste in accordance with 105 CMR 480.000: Minimum Requirements for the Management of Medical or Biological Waste.

**105 CMR 430.160(I):** When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be disposed of as follows:

- (1) Prescription medication shall be properly disposed of in accordance with state and federal laws and such disposal shall be documented in writing in a medication disposal log.
- (2) The medication disposal log shall be maintained for at least three years following the date of the last entry.

## ADDITIONAL REQUIRED CAMPER FORMS

Camper forms must include a copy of this camper's:

- 1) **most recent physical exam** (*including physician's signature*)
- 2) **current immunization record** (*for requirements, please visit: <https://www.mass.gov/info-details/school-immunizations#school-and-camp-requirements->*),  
and a copy of your child's Covid-19 vaccine if they have received the vaccination and it is not noted on their immunization record.
- 3) (*if applicable*) **IEP, 504b, individual health care plan.**