FOR OFFICE USE ONLY

CAMP #_____

DEPOSIT_____

CK#_____

2018 GLISSON CAMP AND RETREAT CENTER: SPARROWWOOD APPLICATION

First Choice: Session_____ Date_____

Second Choice: Session_____ Date_____

Third Choice: Session_____ Date_____

Camper's Full Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Date and Place of Birth: _____ **Age:**_____

Height: _____ **Weight:**_____ **T-shirt size:**_____**Gender:**_____**Ethnicity (optional):**_____

Camper lives with: _____**Relation:**_____

School or Center Camper Attends: _____

Church Affiliation: _____**Years attended Sparrowwood:** _____

Type of residence: Private: _____Group Home: _____ Institution: ____Other: _____

If your camper is over the age of 18, do they have a personal representative? _____ If yes, please include the name and phone number below:

Personal Representative: _____**Phone:**_____

Parents/Guardian's Names:

_____

Current Address if different:

_____

Parent or Guardian

Phone: (day) _____ (night) _____

(cell)_____ (Email) _____

Emergency Contact: _____

Phone: (day) _____ (night) _____

(cell)_____

Social Worker(if applicable): _____

Phone: (office) _____ (home) _____

(cell)_____ (Email) _____

Cabin Mate request_____

What are two areas that you would like to see growth and learning from your camper during their week at camp?

1._____

_____

2._____

_____

****Please attach a recent picture of your camper to aid us with greeting him/her at check-in.**

Basic Camper Criteria

Physical Abilities

1. All Applicants Must Be Ambulatory.
2. Able to function in a program involving lots of walking/hiking, swimming, boating, archery, etc.

Self- Help Skills

1. Uses toilet appropriately (able to wipe self and regulate bathroom needs through the night). Episodes of incontinence are not normal.
2. Capable of washing, dressing, and eating independently (or with minimal help).
3. Females: Has an understanding and awareness of, is able to cope with, and independently provides necessary hygiene during menstrual cycle.

Social Skills

1. Able to communicate needs whether verbally or non-verbally.
2. Able to relate appropriately to other campers and leadership in a *structured* program with a 1:2 staff to camper ratio.
3. Able to stay within physical boundaries of camp setting with no wandering.
4. Free from any self-abusive or aggressive behaviors towards others.

Medical Conditions

1. Seizures – controlled (no more than one seizure per month).
2. Able to eat most normal adult table foods (controlled diabetics acceptable).

I have read the above, and this camper meets the criteria listed. (Please initial here) _____

Camper's Name (Goes by) _____

CAMPER INFORMATION SECTION

THIS INFORMATION SECTION MUST BY FULLY COMPLETED FOR **FIRST TIME** AND **RETURNING** CAMPERS, IN ORDER TO PROVIDE COUNSELORS WITH INFORMATION NECESSARY TO MAKE THE CAMPING EXPERIENCE MOST BENEFICIAL. THIS APPLICATION WILL NOT BE CONSIDERED IF IT IS RETURNED INCOMPLETE, WITHOUT THE ENCLOSED MEDICAL FORM OR THE REQUIRED DEPOSIT.

Please attach most recent Psycho-Social Evaluation

MEDICAL HISTORY: (Please check the appropriate places and explain as necessary.)

Primary Diagnosis: _____

Intelligence Quotient: ( ) Mild (IQ 70-50) ( ) Moderate (IQ 50-40) ( ) Severe (IQ 40-20)

Condition	Acute	Chronic	Explanation, including any physical or functional disability
Tuberculosis	( )	( )	_____
Hepatitis B	( )	( )	_____
Bleeding Disorders	( )	( )	_____
Rheumatic Fever	( )	( )	_____
HIV Positive	( )	( )	_____
Heart Disease	( )	( )	_____
Asthma	( )	( )	_____
Other	( )	( )	_____

Does the camper have any food or drug allergies? ( ) YES ( ) NO

If yes, please list: _____

Reaction? _____

Does the camper have a history of Diabetes? ( ) YES ( ) NO

If yes, how is it controlled? _____

Does the camper have a history of seizures? ( ) YES ( ) NO

If yes, how is it controlled? _____

Describe behavior before, during, and after the seizure: _____

_____

Any hospitalizations, accidents, surgery, or serious illness within the past 12 months? ( ) YES ( ) NO

If yes, please explain: _____

In the unusual case that your camper should be injured at camp, please describe the typical pain response. (i.e. does not communicate pain, has very high tolerance for pain, or over dramatizes the situation.)

_____

_____

Is skilled health care required for this person other than administration of medication? ( ) YES ( ) NO
If yes, what kind of care? _____

_____

_____

_____

SKILLS FOR DAILY LIVING (The following information will allow us to plan appropriate activities that will help ensure a positive camp experience. Please be specific in your answers, and use another piece of paper if necessary.)

Behavior & Peer Relations
Relates to others ( ) Well ( ) Poorly
Explain: _____

Agitated in large groups or by large amounts of noise: ( ) Never ( ) Seldom ( ) Often

Explain: _____

Displays of physically self-abusive behavior within the past 12 months? ( ) NO ( ) YES
Explain: _____

Displays of physically/sexually aggressive behavior towards others in the past 12 months? ( ) NO ( ) YES
Explain: _____

What might prompt these inappropriate behaviors? _____

_____

Positive ways to motivate camper: _____

_____

Please note any fears or frustrations which may lead to behavior problems: _____

_____

Speech & Communication
( ) Verbal ( ) Non-Verbal ( ) Signing ( ) Points, grunts, etc. ( ) Verbalizes basis needs
If camper is non-verbal, please explain in detail their ability to communicate and how best to communicate with them:

_____

_____

Describe any limitation in the following areas:
Vision _____

Hearing _____

Comprehension & Memory

Know own name:	( ) YES	( ) NO
Follows simple directions:	( ) YES	( ) NO
Oriented to time and place:	( ) YES	( ) NO

Mobility
Is the applicant able to participate in the normal pace of activities (walking, hiking, sports, swimming, etc.) or do exceptions need to be made for a slower pace (more rest, sitting out of some activities, etc.)?
( ) Little or no rest between activities ( ) Some rest between activities ( ) A lot of rest between activities

Limitations in Gross Motor Skills (i.e., walking, running) _____

_____

Camper's Name (Goes by) _____

Limitations in Fine Motor Skills (i.e., writing, drawing, buttons/zippers) _____

_____

Eating Patterns
( ) Totally Independent ( ) Minimal Assistance ( ) Cannot feed self ( ) Other (include food allergies)
Able to eat regular diet ( ) Yes ( ) No
Requires special diet ( ) Yes ( ) No If yes, specify: _____

_____

Sleeping Patterns
( ) Normal ( ) Restless ( ) Hard to wake ( ) Talks in Sleep ( ) Wanders/Sleepwalks
Explain: _____

What helps your camper get to sleep?_____

Grooming: (5 is total self-sufficient, 1 is total reliance)

Circle One:	**Self-Sufficient**		**Some assistance required**		**Complete Reliance on Staff**
Showering	5	4	3	2	1
Dressing	5	4	3	2	1
Dental care	5	4	3	2	1
Using toilet	5	4	3	2	1
Menstrual care*	5	4	3	2	1

(*for females only)

****

ESSENTIAL INFORMATION WITHHELD IN REGARDS TO THE EXTENT OF THE CAMPER'S DISABILITIES, RESULTING IN INJURY TO SELF OR OTHER CAMPERS, OR DAMAGE TO THE CAMP PROPERTY, WILL BE CONSIDERED THE FINANCIAL/LEGAL RESPONSIBILITY OF THE PARENT, GUARDIAN, OR CARE PROVIDER.

Name of Person Completing this Application:

Name: _____ **Relationship:** _____ **Phone:** _____

Signature: _____ **Date:** _____

Agency: _____ **Phone:** _____

****

MEDICATION RECORD

It is vitally important that all prescribed medications are brought to camp in their ***original packaging with current dosage*** *from the pharmacy, with the camper's name and doctor's name clearly visible. Campers* ***will not*** *be permitted to stay if medications are pre-packaged in any type of cassettes, baggies, envelopes, etc.* While at camp, the camp nurse will oversee the administration of all medications except for inhalers, prescription creams, shampoos, or oral rinses.
I give permission to the healthcare team to administer and oversee the administration of prescription medication (as noted below) and over-the-counter medication (PRNs).

SIGNATURE: _____ **DATE:**_____

Please share in the space below medications that your camper routinely takes. Our healthcare team will use this information to prepare for your camper's arrival and to ensure they have an opportunity to ask any questions needed prior to your arrival. (At check-in you will bring with you a filled out Glisson Check-In Form that will have more detailed information.)

Name of Drug	**Times Given**	**Reason for Medication**
Example: Mellaril	Breakfast and dinner	Behavior

Background checks are required for campers and staff 18 years of age and older and will be processed at the expense of North Georgia Camp and Retreat Ministries. Information returned through background checks will be utilized as a part of the camper application process and may result in our inability to approve a camper's application for Sparrowwood. Please fill out the following information in its entirety.

FOR CAMPERS 18 YEARS OF AGE AND OLDER ONLY:

I hereby authorize Glisson Camp and Retreat Center to request CampBackgroundCheck.com Inc. or any entity chosen by the camp specifically for conducting this search to release information regarding any record of charges or convictions contained in its files, or in any criminal file maintained on this adult camper whether said file is a local, state, or national file, and including but not limited to accusations and convictions for crimes committed against minors, to the fullest extent permitted by state and federal law. I do release CampBackgroundCheck.com Inc. and other entities from all liability that may result from any such disclosure made in response to this request.

_____ _____

Signature of adult camper or legal guardian Date

Print adult camper's full name:_____

Print all other names that have been used by applicant (if any):_____

Street address:_____

City, State, Zip:_____

Social Security #:_____ Date of Birth:_____

Place of birth:_____

If applicable:
Driver's license #:_____ State issuing license:_____

License expiration date:_____

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Mail this form to the address below by _____ (date)

Dates will attend camp: from _____ (Month/Day/Year) to _____ (Month/Day/Year)

Camper Name: _____ (First) _____ (Middle) _____ (Last)

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp: _____

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1) ***Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.***
2) ***Send the original, signed FORM 1 to camp by the requested date.***
3) ***Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.***
4) ***After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.***

Camper Home Address: _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code)

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Email: _____

Home Address: _____ (If different from above) (Street Address) (City) (State) (Zip Code)

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Allergies: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(Please describe below what the camper is allergic to and the reaction 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 activities of the camp and feel the camper can participate without restrictions.
☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. ***(Please describe below.)***

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_____ Policy Number_____

Subscriber_____ Insurance Company Phone Number (_____) _____

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.

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 _____ (First) _____ (Middle) _____ (Last) (For Camp Use) Cabin or Group_____ (For Camp Use) Session Code(s): _____

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

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
Diptheria, 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) ☐Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative	☐ Positive

If your camper has not been fully immunized, please sign the following statement: **I understand and accept the risks to my child from not being fully immunized.**

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

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
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐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)
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)

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

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

Has/does the camper:

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

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 that may affect the camper's ability to fully participate in the camp program. ***Attach additional information if needed.***

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

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Individual Health Record (For Camp Use Only)

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

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

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

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: _____

CAMPER HEALTH-CARE RECOMMENDATIONS by LICENSED MEDICAL PERSONNEL FORM 2

Developed and reviewed by American Camp Association, American Academy of Pediatrics, Council on School Health & Association of Camp Nurses

Mail this form to the address below by _____ (date)

To Parent(s)/Guardian(s): Complete this section and give this form (FORM 2) and a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1) to your child's health-care provider for review.

Dates will attend camp: from _____ (Month/Day/Year) to _____ (Month/Day/Year)

Camper Name: _____ (First) _____ (Middle) _____ (Last)

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp _____

Camper home address: _____

_____ (City) _____ (State) _____ (Zip Code)

Custodial parent(s)/guardian(s) phone: (_____) _____ (_____) _____

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

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

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)
Chlorpheneramine maleate
Guaifenesin
Dextromethorphan
Diphenhydramine (Benadryl)
Generic cough drops
Chloraseptic (Sore throat spray)
Lice shampoo or scabies cream (Nix or Elimite)
Calamine lotion
Bismuth subsalicylate (Pepto-Bismol)
Laxatives for constipation (Ex-Lax)
Hydrocortisone 1% cream
Topical antibiotic cream
Calamine lotion
Aloe

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today: ☐ Yes ☐ No **(If "No," date of last physical:** _____ (Month/Day/Year)**)**

ACA accreditation standards specify physical exam within last 24 months.

Weight: _____ lbs Height: _____ ft _____ in Blood Pressure _____/_____

Allergies: ☐ No Known Allergies

☐ To foods ***(list):***

☐ To medications: ***(list):***

☐ To the environment ***(insect stings, hay fever, etc.– list):***

☐ Other allergies: ***(list):***

Describe previous reactions:

Diet, Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions: ***(describe below)***

The camper is undergoing treatment at this time for the following conditions: ***(describe below)*** ☐ None.

Medication: ☐ No daily medications. ☐ Will take the following prescribed medication(s) while at camp: ***(name, dose, frequency—describe below)***

Other treatments/therapies to be continued at camp: ***(describe below)*** ☐ None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes

If you answered "Yes" to the question above, what do you recommend? ***(describe below—attach additional information if needed)***

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically, emotionally, and socially fit to participate in an active camp program (except as noted above)."

Name of licensed provider(Please print):_____ Date:_____

Signature:_____ Phone:_____

Office address_____

Camper Name _____ (First) _____ (Middle) _____ (Last)

(For Camp Use) Cabin or Group_____

(For Camp Use) Session Code(s):_____

Sparrowwood Packing List

Luggage:
Large duffel bag or suitcase

Outerwear:
Rain jacket or poncho
Sweatshirt/ Light Jacket

Footwear:
Closed toe shoes(required for adventure activities)
Water shoes with heel strap
Extra pair of shoes in case of rain

Camp Clothing:
Comfortable camp clothes for **six** days (shorts and t shirts are the norm)
1 pair of pants/jeans (required if attending horse camp)
Socks & underwear
One-piece swim suit
Hat/bandana

Sleeping:
Sleeping bag OR bedding for single and double bed
Pillow
Pajamas

Camp Gear:
Water bottle (leak proof)
Flashlight/headlamp
Day pack
Insect repellant
Sunscreen/lip balm

Personal Items:
Washcloths
Towels/Beach towel
Toiletries (soap, shampoo, toothbrush/toothpaste, etc.)

Optional Items:
Camera
Musical instrument
Large plastic bag for wet/dirty clothes

Medication:
Prescription medications: Please follow directions on medication form.
Remember all medications must be in original packaging.

Label all clothes and personal items before you come to camp!

DO NOT BRING: Cell phones or devices with screens, music players, tobacco, alcohol, drugs, fireworks, firearms, pets, flip flops, water guns, any expensive or valuable personal items