

Summer Camp Activities

1. Fast Friends- Donation Collections
2. Swimming
3. Biking Trip
4. Field Games- Parachute Games
5. Garden Meals
6. Low Ropes and Outdoor Survival
7. Ice Cream-Walk
8. Petting Zoo Brattleboro Retreat- Grafton Cheese Company -Tasting
9. Candy Making- Movie Willy Wonka (Rainy Day)
10. Arts and Crafts- Balloon Animal Making, Masks and Animal Paper Mache making

Field Trips:

Fun Spot

Paths of Life

Tell Us About Your Camper!

Please use this form to tell us a little about your camper. Please feel free to include things like their likes and dislikes, hobbies or sports they do, any special needs they may have as well as anything else you feel we need to know in order for your camper to have an enjoyable time at camp.

- My camper likes to:

- My camper doesn't like to:

- My camper is scared of:

- My camper spends most of their time:

- My camper thrives in an environment that is:

- My camper has a difficult time in situations when:

- My camper has a history of (circle all that apply):

Running away Violent Behavior Problems in School Other_____

- Is there a councilor or therapist who you would feel comfortable letting us talk to so that your child will be successful at camp? If yes, please complete and sign the consent form on the back of this sheet.

Please include any other information about your camper you feel is important in creating a comfortable environment for your camper as well as the other campers in the group.

Scholarship Information and Application
MANY Option Summer Camp 24 Vernon Street, Keene, NH 03431
603-355-3040

Dear Parents and/or Guardians,

Due to generous contributions from local organizations, we are able to provide scholarship assistance to a number of youth who wish to attend MANY OPTIONS Summer Camp. Scholarships are awarded based on need and on a first come first serve basis. You may be eligible for assistance that will cover up to 50% of the advertised price of camp tuition. **Depending on the number of families requesting scholarship assistance, it may be possible to receive more than 50% off camp tuition.** We encourage families to seek alternate funding sources.

Please fill out the form below and return it as soon as possible if you wish to be considered for scholarship assistance. Do not hesitate to contact me if you have any questions or concerns with the scholarship application process.

Thank you,

Jessica Francese
Many Options Coordinator

Parent/Guardian Name: _____ Phone: _____

Camper Name: _____ Age as of July 2, 2009 _____

Household size: _____ Household Income/Year: _____

**(*You must attach proof of household income
such as pay stub*)**

Does your family currently receive TANF? Yes No

I _____ confirm that the information I have provided is accurate to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____

MANY Options Summer Camp
Scholarship Info

Table 1

Household Size	Household Income/year	Camp Scholarship
2	Less than 24,384	Up to 50% awarded
3	Less than 30,576	Up to 50% awarded
4	Less than 36,768	Up to 50% awarded
5	Less than 42,960	Up to 50% awarded
6	Less than 49,164	Up to 50% awarded
7	Less than 55,356	Up to 50% awarded
8	Less than 61,548	Up to 50% awarded

Table 2

Household Size	Household Income/year	Camp Scholarship
2	Less than 38,490	Up to 25% awarded
3	Less than 48,270	Up to 25% awarded
4	Less than 58,050	Up to 25% awarded
5	Less than 67,830	Up to 25% awarded
6	Less than 77,610	Up to 25% awarded
7	Less than 87,390	Up to 25% awarded
8	Less than 97,170	Up to 25% awarded

Above is an estimate of the amount of scholarship assistance you may be eligible for. It does not guarantee the amount of assistance you will receive. You must fill out and submit the scholarship application from in order to be eligible along with proof of household income. MANY Options Summer Camp has a set amount of money in the scholarship fund. For this reason, scholarships are awarded on a first come basis.

If you have any questions, please contact Jessica Francese, Many Options Coordinator, at (603)355-3040.

**Monadnock Family Services Challenge Program
Participant Information & Medical Questionnaire
Phone: 603-355-3040 Address: 24 Vernon Street Keene, NH 03431**

Part I: Disclosure

Participants, in all Challenge Program activities, must provide proof of health/accident insurance. The Participant recognizes and acknowledges that the Challenge Program is voluntary and the failure to provide such proof may result in denial of participation in the program. In addition, certain health/medical information must be made known on a case by case basis to the instructor conducting the program, so that they may respond appropriately as circumstances warrant. This information may be turned over to emergency medical personnel in order to ensure appropriate care. Participants in the Challenge Program are always free to choose the level of their involvement. Yet, there is a risk, which must be assumed by each participant, that he or she may suffer an emotional or physical injury and/or disability and possible death.

Part II: General Participant Information

Participant Name:

Mother/Guardian Name and Mailing Address:

Father/Guardian Name and Mailing Address:

School and Grade:

Sex: _____ **Age:** _____

Date Of Birth: _____

Part III: Health/Accident Insurance Information

Insurer's Name & Policy Number:

Part IV: Medical Information

Date (month/year) of most recent physical examination: _____

Has Participant Had A Tetanus Shot or Booster? Yes ___ No ___

Date of Tetanus Shot

(month/year): _____

Is the participant currently taking any prescription or non-prescription medication?

Yes ___ No ___

If yes, please list:

Does the participant have any physical challenges, limiting physical disabilities (temporary or permanent) or medical limitations (temporary or permanent) that may affect their ability to participant in the program?

Yes ___ No ___ If yes, please explain:

Does the participant have any mental health challenges that may affect their ability to participate in the program? Yes ___ No ___

If yes, is there a counselor or therapist who you would feel comfortable letting us talk to so that your child will be successful at MANY Options? If so, please list their name and contact information.

Does the participant have any allergies (including medication and food allergies or reactions)? Yes ___ No ___

If yes, please list allergies and explain severity of reactions as well as medication that is use by the participant in the event of a reaction:

Has the participant undergone surgery in the past two years, or had any procedure that has had lasting effects? Yes ___ No ___

If yes, please explain and give dates:

Currently under follow up care? Yes ___ No ___

If yes, please explain:

Has the participant had:

Any fractures or broken bones in the past year? Yes ___ No ___

Any knee, back or neck injuries? Yes ___ No ___

If yes, please explain, including any limitations still relevant:

Does the participant or the participants family have a history of heart disease or heart related issues, stroke, high blood pressure or chest pain or pressure? Yes ___ No ___

If yes, please explain:

Does the participant have a history of cardiac related symptoms brought on by exertion?

Yes ___ No ___

If yes, please explain:

Does the participant have or has had any of the following? If yes, please explain in space provided below the checklist (Please circle Yes or No).

Yes No Diabetes (Indicate if participant is insulin dependent or not)

Yes No Epilepsy or Seizures (Explain severity, frequency and if currently on medication)

Yes No Asthma (Explain typical treatment needed if participant is having an attack)

Yes No Dizziness, Fainting, Vertigo, Balance and/or Coordination Problems

Yes No Nerve Damage

Yes No Hot/Cold Weather Injuries (Frostbite, Hypo/Hyperthermia, Heat Exhaustion, etc.)

Yes No Severe Burn Injury

Please explain circled items here:

Part V: Emergency Information

Please provide all relevant information:

Mother/Guardian's Name:

Father/Guardian's Name:

Home Phone: _____

Home Phone: _____

Work Phone: _____

Work Phone: _____

Other number(s) they can be reached at

Other number(s) they can be reached at:

**Please provide a person to contact in the event the above can
not be reached during an emergency:**

Name: _____

Relationship to participant: _____

Home Phone: _____

Work Phone: _____

Other number this contact can be reached at:

**Monadnock Family Services Challenge Program
Disclosure & Participant Release of Liability
Phone: 603-355-73040 Address: 24 Vernon Street Keene, NH 03431**

Part VI. Release of Liability

I understand that parts of the Challenge Program may be physically and/or emotionally demanding. I affirm that I am in good health and that I do not have an undisclosed condition that bears upon my fitness or ability to participate in the Challenge Program. I affirm the medical information, which has been provided, is accurate and complete. I understand that the failure to disclose this information could affect my own safety, and the safety of those around me, and I agree to hold Monadnock Family Services harmless if full disclosure of a pre-existing medical condition has not been shared. I recognize the inherent risk of injury, disability and possibly death for my participation in certain Challenge Program activity choices. I release Monadnock Family Services, the Keene YMCA, the city of Keene, and their respective board of directors, and employees and staff members from all liability for any injury to myself arising out of participation in Challenge Program activities.

Participants Name (please print clearly): _____

Signature: _____ Date: _____
(Participant if over the age of 18)

Parent/Legal Guardian

I hereby attest that I am the legal guardian of the participant and that I have the authority to sign this legal document in the interest of this participant. I understand that my child will be faced with inherent risk due to the nature of participation in certain MANY Options After School Program activities, and I agree to the above disclosure and release of liability as the parent/legal guardian to the participant.

Legal Guardian's Name (please print clearly): _____

Signature: _____ Date: _____

Part VIII. Transportation Permission Slip

Participant Name: _____

By signing this form I give my permission, as legal parent/guardian, to the participant listed above to travel in the YIO (Youth Initiatives Office, run through MFS) 15 passenger van with the Challenge Program staff members. I understand that all drivers have valid drivers licenses and have passed background and driver history checks.

Legal Guardian's Name (please print clearly) _____

Signature: _____ Date: _____
(Legal guardian of participant)

Transportation Authorization Form

Camper's Name: _____

Dates attending camp: _____

I, as legal guardian of the above listed camper, give the following individual(s) permission to pick up my camper from Challenge Adventure Camp:

1. Name: _____ Relationship to camper: _____
2. Name: _____ Relationship to camper: _____
3. Name: _____ Relationship to camper: _____

I understand that only myself and the people listed on this form will be allowed to pick my camper up from camp. I have informed the parties listed above that they will be required to show ID upon picking my camper up and they are aware of the pick up time frame.

Walkers:

- By checking this box I am giving the camper listed on this form permission to walk home. I understand that at 4:00pm my camper will be allowed to leave the camp office and he/she is no longer the responsibility of the Challenge Adventure Camp staff.

Please read and sign below:

I have read this form and filled it out according to how I wish my camper to be dismissed from camp. I understand that if I need to make changes to this form I must come to the office in person to do so.

Signature: _____ Date: _____
(parent/legal guardian)

We understand that some families may have certain concerns about people who are not authorized to have contact with their camper. We will not let your camper leave with anyone but yourself and those listed on this form, but if you feel the need to mention anyone who should not be in contact with your camper please do so below.

**Monadnock Family Services Challenge Program
Participant Information & Medical Questionnaire
Phone: 603-355-3040 Address: 24 Vernon Street Keene, NH 03431**

TO BE FILLED OUT BY PARENT OR LEGAL GUARDIAN

Part I: Disclosure

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Part II: General Participant Information

Participant Name:

Mother/Guardian Name and Mailing Address:

Father/Guardian Name and Mailing Address:

School and Grade:

Sex: _____ **Age:** _____

Date Of Birth: _____

Part III: Health/Accident Insurance Information

Insurer's Name & Policy Number:

Part V: Emergency Information

Please provide all relevant information:

Mother/Guardian's Name:

Father/Guardian's Name:

Home Phone: _____

Home Phone: _____

Work Phone: _____

Work Phone: _____

Other number(s) they can be reached at

Other number(s) they can be reached at:

**Please provide a person to contact in the event the above can
not be reached during an emergency:**

Name: _____

Relationship to participant: _____

Home Phone: _____

Work Phone: _____

Other number this contact can be reached at:

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Participants Name (please print clearly): _____

Signature: _____ Date: _____
(Participant if over the age of 18)

Parent/Legal Guardian

I hereby attest that I am the legal guardian of the participant and that I have the authority to sign this legal document in the interest of this participant. I understand that my child will be faced with inherent risk due to the nature of participation in certain MANY Options After School Program activities, and I agree to the above disclosure and release of liability as the parent/legal guardian to the participant.

Legal Guardian's Name (please print clearly): _____

Signature: _____ Date: _____

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Participant Name: _____

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Legal Guardian's Name (please print clearly) _____

Signature: _____ Date: _____
(Legal guardian of participant)

Transportation Authorization Form

Camper's Name: _____

Dates attending camp: _____

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2. Name: _____ Relationship to camper: _____
3. Name: _____ Relationship to camper: _____

I understand that only myself and the people listed on this form will be allowed to pick my camper up from camp. I have informed the parties listed above that they will be required to show ID upon picking my camper up and they are aware of the pick up time frame.

Walkers:

- By checking this box I am giving the camper listed on this form permission to walk home. I understand that at 4:00pm my camper will be allowed to leave the camp office and he/she is no longer the responsibility of the Challenge/ Many Options Adventure Camp staff.

Please read and sign below:

I have read this form and filled it out according to how I wish my camper to be dismissed from camp. I understand that if I need to make changes to this form I must come to the office in person to do so.

Signature: _____ Date: _____
(parent/legal guardian)

We understand that some families may have certain concerns about people who are not authorized to have contact with their camper. We will not let your camper leave with anyone but yourself and those listed on this form, but if you feel the need to mention anyone who should not be in contact with your camper please do so below.

Camper's Name: _____

Dates attending camp: _____

To be completed by the Family Physician

New Hampshire State law recommends any child attending camp will have had a physical examination within two years of attending camp. Physician's orders for prescription drugs to be taken at camp must be written within the current year.

- Date of most recent physical exam (within the past two years): _____
- Date of most recent Tetanus toxoid (within the past 10 years): _____

Health History

Yes No Allergies (Food, Drug, or Environmental) please specify _____

Yes No Diabetes (Indicate if participant is insulin dependent or not) _____

Yes No Epilepsy or Seizures (Explain severity, frequency, and if currently on medication)

Yes No Asthma (Explain typical treatment needed if participant is having an attack)

Yes No Dizziness, Fainting, Vertigo, Balance, and/or Coordination Problems

Yes No Nerve Damage

Yes No Hot/Cold Weather Injuries (Frostbite, Hypo/Hyperthermia, Heat Exhaustion, Etc)

Yes No Severe Burn Injury

Yes No Does the participant sleep walk?

Yes No ADD/ADHD

Yes No Mood or Mental Health Disorder _____

Yes No Heart Condition (please specify) _____

Yes No Fractures or broken bones in the last year (please specify) _____

Yes No Knee, back or neck injuries in the last year (please specify) _____

Yes No Surgery or procedures with lasting effects in the last two years (please explain) _____

Yes No Is this participant currently under follow up care (please explain) _____

Yes No History of cardiac related symptoms brought on by exertion

- Does this child carry an asthma inhaler? Yes ____ No ____

If yes, does he/she have the knowledge and skills to safely possess and use the asthma inhaler in an outdoor adventure setting (hiking, rock climbing, ropes course)? Yes ____ No ____

Comments: _____

- Does this child carry an Epinephrine Auto-Injector? Yes ____ No ____

If yes, does he/she have the knowledge and skills to safely possess and use the Epinephrine Auto-Injector in an outdoor adventure setting? Yes__ No__

Comments:_____

- Does the participant have any health problems, limiting physical disabilities (temporary or permanent) or medical limitations (temporary or permanent) that may affect their ability to participate in the program? Yes ____ No ____

Comments:_____

Physician Name: _____

(Please print clearly)

I have examined the above child within the past two years. In my opinion the child's condition does not preclude his or her participation in an active camp program.

Signature: _____ Date: _____

(Family Physician)

PHYSICIAN ORDERS FOR PRESCRIPTION MEDICATION

(Must be completed and signed by physician in order for Many Options Summer Camp to give medications)

MEDICATIONS MUST BE IN ORIGINAL CONTAINER. THE DIRECTIONS ON THE CONTAINER MUST MATCH THE PHYSICIAN'S WRITTEN ORDERS. A WRITTEN ORDER SIGNED BY THE PHYSICIAN MUST BE RECEIVED TO AUTHORIZE ANY CHANGE IN DIRECTIONS

Yes No Is this child on any prescription medications?

1. Medication and dosage _____ Times of administration _____
Reason for administration _____

2. Medication and dosage _____ Time of administration _____
Reason for administration _____

3. Medication and dosage _____ Time of administration _____
Reason for administration _____

Physician's Signature _____ MD Phone _____

Please include any notes you feel we may find valuable on the back of this form.
Thank you for your assistance.