



CAMP BARRETT SUMMER REGISTRATION AND INSTRUCTION PACKET 2025

Greetings Parent/Guardian,

Thank you for your interest in Elks Camp Barrett Summer Camp Program. Elks Camp Barrett is the major project of the Elks Lodges of the Maryland, Delaware, and District of Columbia Elks Association. These local Lodges support Camp Barrett and further the mission of Elks Camp Barrett to enable children from all backgrounds to participate in a valuable summer camp experience.

Complete the following packet and return to [**elkscampbarrett@gmail.com**](mailto:elkscampbarrett@gmail.com).

Keep a copy and bring it with you on the day of registration at camp. Please bring the original of the camper's physical examination signed by a physician with you to camp. Please note that campers that do not have a current signed physical examination will not be able to attend camp, no exceptions. Please be sure to have the Physician who is filling out the physical examination form list all medications the child is taking, both over the counter and prescription. We cannot dispense medications not listed on the form. If a medication is listed on the form, the parent must bring or send it with the child to camp. **Bring a 6-day supply of ALL prescription medications and over the counter medications in their original container.**

Please make a copy and bring the original of the camper's physical exam. You may bring a copy of any physical that has been completed within the past year.

CAMP BARRETT SUMMER REGISTRATION 2025 YEAR



SESSION SELECTION Circle Date of Choice

July 13-18 GIRLS 5 NIGHT RESIDENTIAL CAMP (Sun – Friday)

July 20-25 BOYS 5 NIGHT RESIDENTIAL CAMP (Sun – Friday)

CAMPER INFORMATION

Camper's Name _____ Family Last Name _____

Camper's Address _____ Gender M F Grade in Fall _____

City, State, Zip _____ School Attending in Fall _____

Home Phone _____ Other Phone _____ Does child participate in other youth programs or activities?

If so, please list _____

With whom does the child live? _____ Any recent changes in family or living arrangement? _____

Birth date ____ / ____ / ____ (mo/day/yr) How did you hear about Elks Camp Barrett _____

Name Your child wishes to be called at Camp _____ # of Summers has child attended Camp Barrett _____

PARENT/GUARDIAN INFORMATION

Primary Parent/Guardian (1) Name _____ Relationship _____

Day Phone _____ Evening phone _____ Cell Phone _____

Address _____ City, State, Zip code _____

Email address _____

Parent/Guardian (2) Name _____ Relationship _____

Day Phone _____ Evening phone _____ Cell Phone _____

Address _____ City, State, Zip code _____

Email address _____

LOCAL EMERGENCY CONTACTS

Persons authorized to act on behalf of parent (s) if they cannot be reached

(1) Name _____ Home Phone _____

Other Phone _____ Relationship to Camper _____

(2) Name _____ Home Phone _____

Other Phone _____ Relationship to Camper _____

CABIN MATE REQUESTS

Age gaps over two years will not be accommodated. We will try to accommodate these requests as space and staffing allow. Please do not group more than 3 buddies together.

CABIN MATE NAME _____ Page 1 _____

CAMPER/STAFF BASIC HEALTH INFORMATION

you must also complete a camp health and physical exam form

Does your Child have any of the following Disorders? Please attach a note with any other information that will help us work with your child.

____ADD ____Asthma ____Bed Wetting

____ADHD ____Epilepsy/seizures ____Juvenile Diabetes

____Gluten Intolerance ____Sleep Disorder ____Allergies

____PKU ____ODD

____OCD ____Other

Please include note listing any other medical issues symptoms and treatment recommendations.

Medications: List all _____

Will this be the child's first time away from home overnight? ____Yes ____No Is child apprehensive about camp? ____Y ____N

Is there anything we need to know about your child to facilitate a fun and successful time at camp? _____

Describe any unusual family circumstances the Camp Director, Health Care Staff or Counselor should know about _____

For conditions below, please call the camp before enrolling your child to discuss how we can best work with him or her.

- Learning Disability - Does your child have a current I.E.P. (individual education plan)? ____Y ____N (attach plan if possible).
- Physical Impairments or Mobility limitations ____Y ____N
- Speech/Language Impairments? ____Y ____N
- Other health and emotional issues, special needs, etc.? ____Y ____N

INFORMATION SPECIFIC TO CAMP ACTIVITIES

My child may participate in the following activities:

Marksmanship (pellet rifles) ____Yes ____No Archery ____Yes ____No Low Ropes ____Yes ____No

Swimming ____Yes ____No

Swimming Level

____Non-swimmer ____Does not know how to dive ____Cannot swim or dive due to medical condition

Comments about swimming ability and/or limitations _____

Parents/Guardian Signature _____ Date _____

PAYMENTS and DONATIONS (OPTIONAL)

Providing a wonderful camping experience at Elks Camp Barrett costs approximately \$400.00 per week per camper. Elks Camp Barrett is the Major project of the Elks Lodges of the Maryland Delaware and District of Columbia Elks Association. These local Lodges support Camp Barrett and further it's mission to enable children from all backgrounds to participant in a valuable summer camp experience. Individuals able to pay all or some portion of this fee are asked to do so to help defray costs. Inability to pay all or a portion of this fee will not affect the child's ability to attend. Your tax-deductible Campership donation of \$ _____ enclosed. Check/Money Orders made payable to Elks Camp Barrett Thank you for helping us send a child in need to camp!

PARENT/GUARDIAN AUTHORIZATIONS

Please initial that you agree with all items:

___ My child (or ward) has permission to participate in the camp activities and trips during the session for which she/he is enrolled. I understand that camp activities have inherent risks, and that reasonable measures will be taken to safeguard the health and safety of all participants, and authorize the camp to provide appropriate routine and emergency care for my child and any dispensing of medications and/or transportation necessary for that care.

___ I understand I will be notified in case of any emergency, unusual illness or injury affecting my child. In the event I cannot be reached, I hereby authorize the alternate contact people to act on my behalf and authorize the camp to contact a physician to provide whatever medical or surgical treatment is necessary. I accept responsibility for the cost of such medical treatments.

___ I will assure that my child is properly prepared for all activities including having proper clothes and equipment, being in good health and willing and able to participate in all camp activities, and willing and able to abide by camp policies and follow the directions of camp personnel.

___ I give my permission to the camp staff to apply my child's sunscreen and bug repellent if necessary. I will also allow the camp to use their own supply if my child does not have his/her own supply.

___ I will assure that my child will not bring valuables, money, electronic items, weapons, alcohol or illegal drugs to camp. I will monitor my child's use and distribution of any photos taken at camp to assure that they are not used inappropriately or posted on the Internet.

___ I have read and understand the registration procedures, policies and all details in the brochure pertaining to the program my child is attending. I have completed all forms including the registration, Medical and code of conduct forms.

___ I have provided a complete picture of my child's physical, mental, and emotional health, including all medications on this registration form and will provide (on the first day of camp) updated health information in the form provided by Camp Barrett.

___ In the event my child is photographed, filmed or recorded while at camp, Camp Barrett and the Elks of MD, DE and DC may use the photo, film or recording for publicity, promotional or instructional purposes.

Parents Name printed _____

Parent/Guardian Signature _____ Date _____

TRANSPORTATION and RELEASE INFORMATION

ALL PICKUPS ON LAST EVENING OF CAMP SESSION BEGINNING 2PM BUT NO LATER THAN 4:00PM UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE CAMP DIRECTOR:

My child's transportation both TO and FROM camp will be _____

The following adults are authorized to pick up my child at the end of camp:

Name _____ Phone _____

Name _____ Phone _____

Code of Conduct for Camp Barrett Campers

All campers and parents are required to complete the following Camper Code of Conduct. I understand that my behavior affects all those with whom I live at Camp. I agree to

- Follow all the camp rules as provided by my counselor and the Camp Director
- Listen to the counselors and staff and follow their directions
- Participate fully in all camp activities
- Respect other campers and staff, the camp facilities and the natural beauty of the camp
- Stay away from dangerous behaviors that may hurt myself and/or others
- Respect the possessions of others and not take items that are not given to me or owned by me
- Not use drugs, alcohol and/or other possible dangerous substances at camp
- Not bring any weapons, including sharp objects, firearms, and lasers to camp

If I fail to do so, I understand that the following procedures will be taken:

My counselor (assigned to the camper's cabin and who accompanies the camper through the daily schedule) will deal with my disruptive or uncooperative behavior in the following manner:

- Point out the problem to me and clearly define the steps necessary to correct the problem
- Remove me from the group to a time-out area and again point out the problem at hand
- Refer the problem to the camp director or assistant director for further counseling and/or action

If I continue to create problems, I will be removed from the group. This permits my counselor to devote his or her time to the rest of the group. I understand that I will remain under the supervision of the camp director and staff until the problem can be resolved. If the above steps fail to correct the problem, the camp director will decide whether I should remain at Elks Camp Barrett or be should be sent home.

If I am to be sent home, my parent will be called and arrangements will be made for me to be picked up.

I understand that following actions will result in immediate contact with my parents or guardians and my immediate removal of the camper from the Camp Barrett.

- Possession or use of a controlled substance
- Deliberate acts that result in injury or death of wildlife
- Deliberate acts that result in the destruction of individual or camp property
- Negative behavior toward another person (foul language, physical/emotional harm)

I have discussed these rules with my parents/guardians and agree to follow them while at Camp Barrett

Signature of Camper _____

Printed Name of Camper _____

Signature of Parent/Guardian _____ Date _____

CAMPER/STAFF HEALTH HISTORY AND INFORMATION

Dates of Camp Attendance _____

The information on this form is not part of the camper or staff acceptance process but is gathered to assist us in identifying appropriate care. This form, except for the "Health Recommendations of Licensed Medical Personnel", is to be filled in by parents/guardians of minors or by adults themselves. ENSURE THAT ALL SIGNATURE BOXES ARE COMPLETE.

Camper/Staff Name _____ Birth Date _____ Age (at camp) _____

Home Address _____

Street Address City State Zip Code

Gender ___ Male ___ Female

Custodial Parent /Guardian _____ Phone _____

Home Address _____ E-mail Address _____

(if different from above) Street City State Zip Code

Business Address _____ Phone _____

Street City State Zip Code

Second Parent/Guardian/Emergency Contact _____

Business Address _____ Phone _____

Street City State Zip Code

If not available in an emergency, notify: Name _____
Relationship _____

Address _____ Phone _____

Street City State Zip Code

INSURANCE INFORMATION

Is the Participant covered by family medical/hospital insurance? ___ Yes ___ No

If so, Indicate Carrier or plan name _____ Group # _____

Name of Insured _____ Relationship to Patient _____

Carrier Address _____ Insurance ID number _____

Important These boxes must be completed for attendance and permission to provide Necessary Treatment or Emergency Care:

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event, I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staffer _____

I also understand and agree to abide by the restrictions placed on my camp activities.

Camper Signature _____

Witness _____ Date _____

(Please print clearly or type) CAMPER/STAFF HEALTH HISTORY

The following information must be filled in by the parent/guardian, adult camper or staff member. The intent of this information is to provide camp health care personnel with the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so the camp can be aware of the camper's needs.

ALLERGIES

Describe reaction and management of the reaction. Medication, Food, Insect Stings. Hay Fever, Animal Dander etc.

Campers are to bring in the original container a 7-day supply of ALL prescription medication.

GENERAL QUESTIONS - Please explain any YES answers below noting the number of the question.

Has/Does the participant:

- | | | | |
|--|-----------|---|-----------|
| 1. Had any recent injury, illness or infectious disease? | Yes or no | 16. Ever been dizzy during or after exercise? | Yes or no |
| 2. Have chronic or recurring illness/condition? | Yes or no | 17. Ever had an eating disorder? | Yes or no |
| 3. Orthodontic appliance being brought to camp? | Yes or no | 18. Ever had seizures? | Yes or no |
| 4. Ever had problems with joints? | Yes or no | 19. Ever had emotional difficulties with professional help? | Yes or no |
| 5. Ever been hospitalized? | Yes or no | 20. Ever had chest pain during or after exercise? | Yes or no |
| 6. Ever had surgery | Yes or no | 21. Have asthma? | Yes or no |
| 7. Have frequent headaches? | Yes or no | 22. Ever had high blood pressure? | Yes or no |
| 8. Ever had a head injury? | Yes or no | 23. Have any skin problems? | Yes or no |
| 9. Ever been knocked unconscious? | Yes or no | 24. Have diabetes? | Yes or no |
| 10. Have problems with diarrhea/constipation? | Yes or no | 25. Had mononucleosis in the past 12 months? | Yes or no |
| 11. Wear glasses, contacts, or protective eye wear? | Yes or no | 26. Ever been diagnosed with a heart murmur? | Yes or no |
| 12. Have problems with sleepwalking? | Yes or no | 27. Ever had back problems? | Yes or no |
| 13. Ever had frequent ear infections? | Yes or no | 28. If female, have an abnormal menstrual history? | Yes or no |
| 14. Ever passed out during or after exercise? | Yes or no | | |
| 15. Have a history of bed-wetting? | Yes or no | | |

Parent /Guardian Signature _____

Name of Family Physician _____ Phone _____

Address _____

City State Zip Code

Name of Family Dentist/Orthodontist _____ Phone _____

Address _____

City State Zip Code

CAMPER/STAFF PHYSICAL EXAMINATION

(you must also complete a camp health form)

INDIVIDUALIZED ORDER FOR: _____

Prescription Medications (Please complete with patient's current regimen for both scheduled and PRN medications).

Drug	Dosage	Schedule	Comments

Standard Over the Counter/PRN Medications

(meds available in the Infirmary/First Aid Kits to be administered at the discretion of the RN):

Drug	Dosage	Schedule	Provider Order	Comments
Tylenol	Per label instructions by age/weight	Q 4hr pm for pain or Fever	yes/ no	
Ibuprofen	Per label instructions by age/weight	Q 6hr pm for pain or Fever	yes/ no	
Robitussin	Per label instructions by age/weight	Q4hr for cough	yes/ no	
Pepto-Bismol	Per label instructions by age/weight	Q 30 min to 1 hour prn For diarrhea	yes/ no	
Children's Mylanta	Per label instructions by ag weight	BID-TID pm for stomach upset	yes /no	
Dimetapp	Per label instructions by age/weight	Q 6-8 hr pm for nasal congestion/drainage	yes/no	
Benadryl	Per label instructions by age/weight	Q 6hr prn for allergic reaction (insect bites/hives)	yes / no	
Insect Repellent	Per label instructions by age/weight	As needed	yes /no	
Calamine Lotion	Per label instructions by age/weight	As needed	yes /no	

IMMUNIZATIONS - Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP						
TD (tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Haemophilus influenza B						
Hepatitis B						
Varicella (chicken pox)						
BCG						

Mo/Yr
Which of the following has the participant had?
 Measles
 Chicken Pox
 German Measles
 Mumps
 Hepatitis
 TB Mantoux Test
 Test Date _____
 Result: _____

The Camp Nurse has reviewed the camp health form and physical examination forms on the day of

Camper / Staff Member Name _____

I have examined the above camp participant.

Date of last examination _____

Blood Pressure _____
Temp _____

Weight _____ Height _____

In my opinion, the above applicant _____ is _____ is not able to participate in an active camp program.
The applicant is under the care of a physician for the following conditions:

Current treatment at the time of this report includes

Recommendations and Restrictions at Camp

Treatment to be continued at camp (Please be specific. Include type, and schedule)

Medications to be administered at camp (prescription and OTC)

(Each medication must be listed on the chart on page 7 - Individualized Orders)

Any medically prescribed meal plan or dietary restrictions:

Known allergies:

Description of any limitations or restrictions on camp activities:

Additional information for health care staff at the camp:

Signature of Licensed Physician _____

Printed Name and License Number _____

Date _____ **Physicians Phone Number** _____

***If you don't have a
signed physical form
within the past year
take the form above
to the physician***

IMPORTANT NOTE

**DID YOU PRINT A
COPY OF THIS FORM?**

**REMEMBER YOU
MUST PRINT THIS
FORM AND MAIL OR
SCAN EMAIL TO**

**ELKSCAMPBARRETT
@GMAIL.COM!**