



Natick Recreation and Parks Department

# 2009 CAMP ARROWHEAD BROCHURE



## NEW REGISTRATION INFORMATION FOR CAMP ARROWHEAD

**NATICK RESIDENTS** can guarantee a spot for their child in either the Day or Residential Camp by returning *Camper Registration Form*, **WHICH MUST BE FILLED OUT IN ITS ENTIRETY**, to the Recreation & Parks Department Office (Cole Center) by Tuesday, March 31, 2009 at 5:00 pm.

Based on availability, **NON-RESIDENTS** may submit the **COMPLETED** *Camper Registration Form* beginning Wednesday, April 1, 2009.

Full payment or a completed Payment Responsibility Form must be submitted with registration.

All campers must submit most recent Physical Form Printout (within 12 months of session end) or completed Medical Exam Form signed by Physician. A Medical Exam Form is available at the Recreation and Parks Department Office. Physical Form (Computer Printout from physician) **or** Medical Exam Form must be submitted to the Recreation and Parks Department Office by Monday, June 1, 2009.

It is imperative that all lines be filled out in some manner. If the information requested does not apply to your child, please place an "N/A" in that spot to show that you have read and understood the question. **YOU MAY JEOPARDIZE YOUR CHILD'S SPOT** if all lines are not filled out and forms signed.

# CAMP ARROWHEAD

## Day Camp

A Camp for disabled individuals who are 5 years old and up. The Camp is located in a beautiful wooded setting on the shore of Lake Cochituate at the Amputee Veteran's site at 1055 Worcester Rd. • Natick, MA 01760. The Camp is sponsored by the NR&PD and PATH (Parents Association for the Handicapped, Inc.) The Camp day begins with "Opening Circle", which includes singing and announcements. The rest of the day includes instructional and recreational swimming, arts and crafts, creative dramatics, music, adaptive sports, life skills program, nature and gardening classes and much more. Special events and field trips are also provided.

Campers should bring a bag lunch that does not need refrigeration and a drink.

A vitamin enriched fruit drink will be provided at all meals by the camp.

Visit our website at <http://www.camparrowhead.us>

## Sessions:

There are (6) one-week sessions, Monday through Friday • 9:00 am - 3:00 pm.

Session 1	June 29	-	July 3	
Session 2	July 6	-	July 10	
Session 3	July 13	-	July 17	
Session 4	July 20	-	July 24	(Practice Overnight - July 24)
Session 5	July 27	-	July 31	
Session 6	August 3	-	August 6	(August 7 is Family Night at Camp. There will be <i>no</i> day camp Aug 7.)

FEE: Natick Resident - \$240/Session • Non-resident - \$300/Session

## DONATIONS FOR CAMP ARROWHEAD

PATH (Parent's Association of The Handicapped) gives financial assistance for "qualified" families. Even with PATH's fundraising, we still have difficulty meeting the needs of qualified families. If you, your friends, your house of worship or place of business are able to help with a donation, we may be able to help more families. Donations are tax deductible.

Checks should be made payable to:

**PATH**  
c/o: Natick Recreation and Parks  
179 Boden Lane  
Natick, MA 01760

## Residential Camp • Ages 10 & Older

Residential Camp is five nights and six days in Cabins at Lions Camp Pride in New Durham, NH. A list of items to bring will be given to each camper who registers. *New campers must attend at least one week of day camp to qualify for residential camp and/or the July 24 "Practice Overnight."*

## Residential Dates and Fees are as Follows:

### DATE:

August 16 - August 21

### FEES:

Natick Resident - \$650 • Non-Resident - \$750

## Health and Safety

- A Camp Nurse will be on site at all times for both the Day Camp and the week of Residential Camp. A Doctor is also on call if needed. Natick Fire Rescue is only minutes away. All waterfront personnel are fully trained as well as being certified in First Aid and CPR. A Medical Authorization Form is required to be filled out completely and signed by the parent(s)/guardian(s) prior to attending camp.

## Staff and Volunteers

- Andrea Roshier and Matt Frechette will be returning as the Camp Directors along with a very impressive staff. Complimenting our staff are volunteers who provide a one to one camper relationship. Volunteers who are 14 years old and older are needed for our camp season. A minimum two-week commitment is required. Applications will be available March 20. Applications must be completed and returned by April 27, 2009.

If you are planning to earn Community Service Credits toward graduation, contact Ms. Samuels or Ms. Tudrick in Room A-104 at Natick High School.

Call the NR&PD at (508) 647-6530 if you would like more information or have questions about Camp Arrowhead.

## Transportation for Natick Residents

- Natick Recreation & Parks Department has limited transportation for only six Natick individuals at the price of \$50/week for the 2009 camp season. This service is available on a first come, first served basis. The Department encourages parents who need this service to act promptly due to 2009 Recreation Department transportation limitations.

**Deadline to submit application to PATH for Financial Aid is June 1, 2009.**

# 2009 • CAMP ARROWHEAD REGISTRATION FORM

Natick Residents can guarantee a spot for their child in either Day Camp or Residential Camp by filling out **both sides of this form in its entirety** and submitting it to the Recreation & Parks Dept. office by **Tuesday, March 31, 2009 at 5:00 pm**

**General Camper Data**

• **One Form for Each Camper**  
• **Please fill out each line on form (If not applicable, place an N/A)**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Last First Middle Initial

Grade Entering Fall, 2009 \_\_\_\_\_ School \_\_\_\_\_ Age (as of 7/1/09) \_\_\_\_\_ M  F

Address \_\_\_\_\_  
Street Town State & Zip Telephone

E-mail address (optional) \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ At Home   
(Mother) Last First Work # Cell #

\_\_\_\_\_ At Home   
(Father) Last First Work # Cell #

Brothers & Sisters Names & Ages \_\_\_\_\_

**Insurance Information**

**MANDATORY: MUST BE FILLED OUT**

Health Plan/HMO: \_\_\_\_\_

Policy or Group #: \_\_\_\_\_

**Photographs/Publicity:**

Please note that photos of your child may be used for various publicity medias.

**Emergency Contact(s) Other Than Parent**  
(Mass. Dept. of Public Health Requires 2 Emergency Contacts)

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

Address: \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_

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

Address: \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_

Session(s) Desired (Please Circle)								Cost
Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Transportation to camp	Residential	
6/29- 7/3	7/6 - 7/10	7/13 - 7/17	7/20 - 7/24 <small>Overnight Practice</small>	7/27 - 7/31	8/3 - 8/6 <small>Family Night 8/7- No Day Camp</small>	1 2 3 <small>Natick Residents Only Circle Session(s)</small>	8/16- 8/21	
			Yes <input type="checkbox"/> No <input type="checkbox"/>			4 5 6		

Optional donation for financial aid for the disabled and financially needy of \$1.00 \$ \_\_\_\_\_

Make Checks Payable to: **TOWN OF NATICK** Total Cost \$ \_\_\_\_\_  
 A \$25.00 fee will be charged for all returned checks

Visa/MC # \_\_\_\_\_ Expiration Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**PARENT/PARTICIPANT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Swimming Skills (Red Cross Tests)**

Non-Swimmer       Swimmer       Other \_\_\_\_\_

**Camper Profile**      If not applicable please place an **N/A** across this section

Primary Diagnosis \_\_\_\_\_  
Secondary Diagnosis \_\_\_\_\_  
Date of Diagnosis \_\_\_\_\_  
Medic Alert # \_\_\_\_\_  
School/Employment Program \_\_\_\_\_ Phone \_\_\_\_\_ Grade \_\_\_\_\_  
Special Needs Teacher/Liaison \_\_\_\_\_ May We Contact This Person?  Y  N  
Emotional/Behavioral Issues \_\_\_\_\_  
Methods Of Communication \_\_\_\_\_  
Intervention Suggestions \_\_\_\_\_  
Other medical/physical issues \_\_\_\_\_  
Hobbies/Interests/Goals \_\_\_\_\_

**Camper Requires or Uses:**

Braces       Crutches       Wheel Chair/Stroller       Prosthesis       Walker  
 Splint       Hearing Aid       Other (i.e., earplugs, etc.) \_\_\_\_\_

Physical restraints (specify) \_\_\_\_\_  
Is camper able to keep track of his/her equipment? \_\_\_\_\_  
Is camper toilet trained?  Yes  No If no, please describe preferred procedures \_\_\_\_\_  
Menstruation?  Yes  No Preferred sanitary procedures \_\_\_\_\_

**If any medications need to be given during camp hours:**

List of Medications: \_\_\_\_\_  
\* Medication Authorization Form must be filled out and returned by June 1, 2009.

**In Case Of A Medical Emergency:**

I understand every effort will be made to contact parents/guardians of campers. In the event that I can not be reached, I hereby give my permission for the following: The physician assigned may secure proper treatment for my child, which may include but not be limited to: hospitalization, order and administer medications and anesthesia, perform x-rays, special procedures or surgery if deemed medically necessary by him/her for my child (name) \_\_\_\_\_.

I realize injuries can occur from participation in sports and other activities. I hereby waive, release, absolve, indemnify and agree to hold harmless The Town of Natick, Natick Recreation and Parks Department, their directors, instructors or assignees from any claim arising out of injury to my children or myself.

**Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# Natick Recreation and Parks Department

## ARROWHEAD 2009 Payment Responsibility

Campers Name: \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_  
Area Code

Address: \_\_\_\_\_  
Street  
Town State Zip

### FILL IN AGENCY/CONTACT PERSON RESPONSIBLE FOR PAYMENT

Agency/  
Contact Person: \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_  
Area Code

Address: \_\_\_\_\_  
Street  
Town State Zip

Agency/  
Contact Person: \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_  
Area Code

Address: \_\_\_\_\_  
Street  
Town State Zip

### SESSION(S) DESIRED

*Please check box(es)*

		<u>Resident</u>	<u>Non-Resident</u>	<u>Amount</u>
<input type="checkbox"/>	SESSION 1 June 29 - July 3	\$240.00	\$300.00	\$ _____
<input type="checkbox"/>	SESSION 2 July 6 - July 10	\$240.00	\$300.00	\$ _____
<input type="checkbox"/>	SESSION 3 July 13 - July 17	\$240.00	\$300.00	\$ _____
<input type="checkbox"/>	SESSION 4 July 20 - July 24	\$240.00	\$300.00	\$ _____
<input type="checkbox"/>	SESSION 5 July 27 - July 31	\$240.00	\$300.00	\$ _____
<input type="checkbox"/>	SESSION 6 August 3 - August 6	\$240.00	\$300.00	\$ _____
<input type="checkbox"/>	Natick Residents Only - Limited Bus Transportation	\$50.00/week		\$ _____
<input type="checkbox"/>	RESIDENTIAL August 16 - August 21	\$650.00	\$750.00	\$ _____
<b>TOTAL</b>				<b>\$ _____</b>

<u>PAID BY</u>	<u>DATE</u>	<u>CHECK #</u>	<u>AMOUNT</u>	<u>BALANCE</u>
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____



# *Natick Recreation and Parks Department*

**"Create Community through People, Parks and Programs"**

January 14, 2009

Dear Parent of Woodtrail/Arrowhead Camper,

The Massachusetts Department of Public Health requires that any medication(s) administered by a licensed day camp needs an **"Authorization to Administer Medication to a Camper" form filled out and signed by the camper's parent or guardian**. Without this form, we cannot administer medication to your son and/or daughter. This form must be filled out completely and returned to the Recreation and Parks Department by Monday, June 1. Please note that only medication(s) provided in the original, pharmacy labeled container will be administered.

Please call us at the Recreation Department at (508) 647-6530 if you have any questions. Thank you in advance for your cooperation in this matter.

Respectfully,

Richard Cugini, Superintendent  
Natick Recreation and Parks Department

/ljp

**CAMP ARROWHEAD • WOODTRAIL CAMP**  
**AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER**  
(To be completed by parent/guardian and countersigned by the Health Care Consultant)

Name of Camper: \_\_\_\_\_ DOB: \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_  
Allergies: \_\_\_\_\_ Home Telephone: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_ Business Telephone: \_\_\_\_\_  
Cell Telephone: \_\_\_\_\_

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Name of Medication: \_\_\_\_\_ Dose given at camp: \_\_\_\_\_ Route of Administration: \_\_\_\_\_  
Frequency: \_\_\_\_\_ Date Ordered: \_\_\_\_\_ Duration of Order: \_\_\_\_\_ Quantity Received: \_\_\_\_\_  
Expiration date of Medications Received \_\_\_\_\_ Special Storage Requirements: \_\_\_\_\_  
Specific Directions (e.g., on empty stomach/with water) \_\_\_\_\_  
Specific Precautions: \_\_\_\_\_  
Possible Side Effects/Adverse Reactions: \_\_\_\_\_  
Other Medications (at parents discretion): \_\_\_\_\_  
Location where medication administration will occur: \_\_\_\_\_

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Name of Medication: \_\_\_\_\_ Dose given at camp: \_\_\_\_\_ Route of Administration: \_\_\_\_\_  
Frequency: \_\_\_\_\_ Date Ordered: \_\_\_\_\_ Duration of Order: \_\_\_\_\_ Quantity Received: \_\_\_\_\_  
Expiration date of Medications Received \_\_\_\_\_ Special Storage Requirements: \_\_\_\_\_  
Specific Directions (e.g., on empty stomach/with water) \_\_\_\_\_  
Specific Precautions: \_\_\_\_\_  
Possible Side Effects/Adverse Reactions: \_\_\_\_\_  
Other Medications (at parents discretion): \_\_\_\_\_  
Location where medication administration will occur: \_\_\_\_\_

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Name of Licensed Prescriber: \_\_\_\_\_ Business Telephone: \_\_\_\_\_  
Emergency Telephone: \_\_\_\_\_

\* All medications on this page are to be given as described under Massachusetts Department of Public Health Camper Regulation CMR 430.160 (A), (C) AND (D). (See Reverse)

## Authorization to Administer Medication (2)

I hereby authorize \_\_\_\_\_ to administer, to my child, \_\_\_\_\_ the medication(s) listed above, in  
(NAME OF CAMP) (NAME OF CHILD)  
105 CMR 430.160.

### 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.

### 105 CMR 430.160(C)

Medication shall only be administered by the health supervisor\* or by a licensed health care professional authorized to administer prescription medications. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration or medications shall be under the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, there is written permission form the parent/guardian and the health care consultant approves in writing the administration of the medications.

### 105 CMR 430.160(D)

When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

\*Health Supervisor - A person who is at least 18 years of age, specially trained and certified in at least current American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Camp Health Care Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dose given at camp: \_\_\_\_\_ Route of Administration: \_\_\_\_\_

Frequency: \_\_\_\_\_ Date Ordered: \_\_\_\_\_ Duration of Order: \_\_\_\_\_ Quantity Received: \_\_\_\_\_

Expiration date of Medications Received \_\_\_\_\_ Special Storage Requirements: \_\_\_\_\_

Specific Directions (e.g., on empty stomach/with water) \_\_\_\_\_

Specific Precautions: \_\_\_\_\_

Possible Side Effects/Adverse Reactions: \_\_\_\_\_

Other Medications (at parents discretion): \_\_\_\_\_

Location where medication administration will occur: \_\_\_\_\_

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Name of Medication: \_\_\_\_\_ Dose given at camp: \_\_\_\_\_ Route of Administration: \_\_\_\_\_

Frequency: \_\_\_\_\_ Date Ordered: \_\_\_\_\_ Duration of Order: \_\_\_\_\_ Quantity Received: \_\_\_\_\_

Expiration date of Medications Received \_\_\_\_\_ Special Storage Requirements: \_\_\_\_\_

Specific Directions (e.g., on empty stomach/with water) \_\_\_\_\_

Specific Precautions: \_\_\_\_\_

Possible Side Effects/Adverse Reactions: \_\_\_\_\_

Other Medications (at parents discretion): \_\_\_\_\_

Location where medication administration will occur: \_\_\_\_\_

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Name of Medication: \_\_\_\_\_ Dose given at camp: \_\_\_\_\_ Route of Administration: \_\_\_\_\_

Frequency: \_\_\_\_\_ Date Ordered: \_\_\_\_\_ Duration of Order: \_\_\_\_\_ Quantity Received: \_\_\_\_\_

Expiration date of Medications Received \_\_\_\_\_ Special Storage Requirements: \_\_\_\_\_

Specific Directions (e.g., on empty stomach/with water) \_\_\_\_\_

Specific Precautions: \_\_\_\_\_

Possible Side Effects/Adverse Reactions: \_\_\_\_\_

Other Medications (at parents discretion): \_\_\_\_\_

Location where medication administration will occur: \_\_\_\_\_

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Emergency Telephone: \_\_\_\_\_

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Frequency: \_\_\_\_\_ Date Ordered: \_\_\_\_\_ Duration of Order: \_\_\_\_\_ Quantity Received: \_\_\_\_\_

Expiration date of Medications Received \_\_\_\_\_ Special Storage Requirements: \_\_\_\_\_

Specific Directions (e.g., on empty stomach/with water) \_\_\_\_\_

Specific Precautions: \_\_\_\_\_

Possible Side Effects/Adverse Reactions: \_\_\_\_\_

Other Medications (at parents discretion): \_\_\_\_\_

Location where medication administration will occur: \_\_\_\_\_

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Name of Medication: \_\_\_\_\_ Dose given at camp: \_\_\_\_\_ Route of Administration: \_\_\_\_\_

Frequency: \_\_\_\_\_ Date Ordered: \_\_\_\_\_ Duration of Order: \_\_\_\_\_ Quantity Received: \_\_\_\_\_

Expiration date of Medications Received \_\_\_\_\_ Special Storage Requirements: \_\_\_\_\_

Specific Directions (e.g., on empty stomach/with water) \_\_\_\_\_

Specific Precautions: \_\_\_\_\_

Possible Side Effects/Adverse Reactions: \_\_\_\_\_

Other Medications (at parents discretion): \_\_\_\_\_

Location where medication administration will occur: \_\_\_\_\_

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Name of Medication: \_\_\_\_\_ Dose given at camp: \_\_\_\_\_ Route of Administration: \_\_\_\_\_

Frequency: \_\_\_\_\_ Date Ordered: \_\_\_\_\_ Duration of Order: \_\_\_\_\_ Quantity Received: \_\_\_\_\_

Expiration date of Medications Received \_\_\_\_\_ Special Storage Requirements: \_\_\_\_\_

Specific Directions (e.g., on empty stomach/with water) \_\_\_\_\_

Specific Precautions: \_\_\_\_\_

Possible Side Effects/Adverse Reactions: \_\_\_\_\_

Other Medications (at parents discretion): \_\_\_\_\_

Location where medication administration will occur: \_\_\_\_\_

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Name of Licensed Prescriber: \_\_\_\_\_ Business Telephone: \_\_\_\_\_

Emergency Telephone: \_\_\_\_\_

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