



## PARENT PACKET SUMMER AND VACATION CAMPS

Dear Parents/Guardians:

Welcome to TSC's Multisports Indoor Adventures Program. Thank you for considering TSC for your family's camp experience. In order to comply with board of health regulations, we will need the following paperwork completed before your child can have fun at our camp. Tyngsboro Sports Center would like to provide your child with the safest environment possible. We understand that we are asking for a lot of information, but to better serve your family, please take a moment to provide detailed answers when filling out the forms.

*TSC Paperwork Checklist – to assist your family in preparation for camp/vacation programs.*

Child's Fact Sheet

Pick-up authorization/Emergency Contact and Release forms

Health Care Policies

Camper's Profile

Physical

Immunization

Authorization for medication form (only applicable if TSC will be administering medication to your camper during camp hours)

### **REMINDER TO ALL PARENTS**

**Each child must be examined by a physician (within the last 18 months) prior to enrollment, as required by the Commonwealth of Massachusetts. Included with this physical is an immunization history. Each child must be immunized prior to entrance at TYNGSBRO SPORTS CENTER. Please be sure that your child's immunizations are up to date at the time of entrance into the camp program. If TSC does not have your child's physical and immunization records at the start of the camp week, entrance will be denied until records are received. TSC will not give refunds if this situation occurs.**

Remember, we are available to assist you in making you and your camper's experience a pleasurable one. If you have any questions or need assistance filling out forms, contact us at 978-649-9393. We are looking forward to a summer of endless opportunities of fun, excitement and personal growth.

Thank you,

*TSC STAFF*



**PARENT PACKET  
SUMMER AND VACATION CAMPS**

**VACATION PROGRAM WAIVER FORM**

Child's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Parent/Guardian's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**HOLD HARMLESS RELEASE FORM**

In consideration of being allowed to participate in any way in the Tyngsboro Sports Center, Inc. programs, related events and activities, the undersigned acknowledges, appreciates and agrees that:

1. The risk of injury from activities involved in this program is significant, including the potential for permanent paralysis and death, and while particular rules, equipment, and personal discipline may reduce this risk, the risk of serious injury does exist; and,
2. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, and assume full responsibility for my participation; and,
3. I willingly agree to comply with the stated and customary terms and conditions for participation. If, however I observe any unusual significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately; and,
4. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS Tyngsboro Sports Center LLC, its officers, officials, agents, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("RELEASES"), WITH RESPECT TO ANY AND ALL INJURY, DISABILITY, DEATH, or loss or damage to person or property; and,
5. In the event that a claim is brought by Participant or Release against the other, the defendant shall be able to recover reasonable attorney's fees if incurred in successfully defending against such claim.

**I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.**

I also understand that TSC regularly takes pictures during our programs that are used for promotional materials and give permission to TSC to use these pictures without compensation.

*We at Tyngsboro Sports Center understand and appreciate specific family concerns and medical issues. If you have any specific requests, please make these concerns in written format to have on file with the camper's registration.*

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release as provided above of all the Releasees, and for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the releases from any and all liabilities incident to my minor child's involvement or participation in these programs as provided above,

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Parent/Guardian Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date Signed \_\_\_\_\_



# PARENT PACKET SUMMER AND VACATION CAMPS

## CHILD FACT SHEET

### CHILD INFORMATION

Child's Name \_\_\_\_\_

### CHILD'S IDENTIFICATION INFORMATION

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Sex: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Skin Color: \_\_\_\_\_

Identifying Marks: \_\_\_\_\_

### PARENT/GUARDIAN INFORMATION

PRIMARY CONTACT *(Authorized To Sign-Out Camper)*

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

Relationship to Child: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

\*Home Telephone #: \_\_\_\_\_

\*Home Address: \_\_\_\_\_

Bus. Name: \_\_\_\_\_

Bus. Address: \_\_\_\_\_

Bus. Telephone #: \_\_\_\_\_

Work Hours: \_\_\_\_\_

\*If different from child's home phone or address

SECONDARY CONTACT *(Authorized To Sign-Out Camper)*

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

Relationship to Child: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Home Telephone #: \_\_\_\_\_

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

Bus. Name: \_\_\_\_\_

Bus. Address: \_\_\_\_\_

Bus. Telephone #: \_\_\_\_\_

Work Hours: \_\_\_\_\_

### MEDICAL INFORMATION

Child's Physician: \_\_\_\_\_

Clinic: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**Has/Does your camper:** *(Please Circle)*

Frequent ear infections:      Yes      No      Diagnosed with ADD/ADHD:      Yes      No

Heart Trouble:      Yes      No      Learning disabilities:      Yes      No

Headaches:      Yes      No      IEP:      Yes      No

Diabetes:      Yes      No      Skin Problems:      Yes      No

Asthma:      Yes      No      If yes, will they have an inhaler?      Yes      No

If you answered yes to any of the above questions please give a detailed explanation: \_\_\_\_\_

Please list all allergies: \_\_\_\_\_

For each allergy, please give a detailed explanation about the causes, symptoms, reactions, and treatments? \_\_\_\_\_

Please list any other medical conditions that we should know about: \_\_\_\_\_

**Will TSC be administering medication during the camp day?**     **No**     **Yes** *(If yes please fill out the consent form)*



# PARENT PACKET SUMMER AND VACATION CAMPS

## AUTHORIZATION AND CONSENT FORM

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However; if I cannot be reached I hereby authorize TYNGSBORO SPORTS CENTER to transport my child to Lowell General Hospital (Lowell, MA) or Saint Joseph’s Hospital (Nashua, NH), and to secure for my child the necessary medical treatment. I understand the staff members of TYNGSBORO SPORTS CENTER are trained in the basics of First Aid and I authorize them to give my child first aid when appropriate.

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

## EMERGENCY CONTACT AND RELEASE FORM

In case of an emergency, please give names of persons who can be called and are authorized to pick-up your child if we cannot reach a parent (please attach another sheet if more room is needed).

**PICK-UP AUTHORIZATION:** At camper sign-out, I authorize the following people to pick up my child from camp: For your child’s safety, A PICTURE ID IS REQUIRED each and every time your child is picked up.

### PICK-UP AUTHORIZATION

### EMERGENCY CONTACT?

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Y N

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Y N

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Y N

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

### **NOT AUTHORIZED TO PICK-UP:**

1. \_\_\_\_\_ 2.) \_\_\_\_\_ 3.) \_\_\_\_\_

## HEALTH POLICIES AND GUIDELINES

TSC does have a healthcare consultant, Doctor Russell Coleman, on-call. Our consultant has advised us on our health policies, and will always be available to advise us in both acute and chronic medical situations. As part of our health care policy, TSC cannot accept any child with a diagnosed communicable disease (measles, mumps, chicken pox, etc). Please do not send your child to TSC if he/she shows signs of possible contagious diseases (new cold, sore throat, fever, rashes, diarrhea, vomiting, etc) TSC does not have sufficient staff or facilities to care for sick children. A parent should not bring their child to our facility if he/she is too ill to participate in activities, if the child requires special attention due to their illness, or if any signs or poor health are evident. The health of all children and staff is in jeopardy if an ill child is allowed to attend. Parents must notify the staff if their child has been exposed to and infectious disease so we can alert the families of the children attending the program. If during the day the TSC staff notices a child is unable to participate in activities due to poor health, the parent will be called to come and pick up the child. If a parent cannot be reached, an emergency contact will be called. It is the responsibility of the parent to notify TSC if there should be any changes regarding emergency numbers or contacts. If you decide that your child should remain at home, please call 978-649-9393 and inform TSC of the absence. You have the right to request in writing to review the background of our counselors and our health care, discipline and grievance policies/procedures.



# PARENT PACKET SUMMER AND VACATION CAMPS

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

**In accordance with Massachusetts State Law, TYNGSBORO SPORTS CENTERS' policy on the administration of medication is as follows:**

-Medication must arrive in the prescription container with date, dosage, and the doctor's name and must include the doctor's order.

-A parent must sign the medication permission form, writing the purpose of the medication, the date and times of administration, and the amount given.

-Medication must be handed directly to an administrator, not left in the child's lunch box or equipment bag.

**TYNGSBORO SPORTS CENTER will not administer the following:**

-Non prescription drugs (unless authorized by parent/guardian and a medication permission form is complete)

-Medication not contained in the prescription package. Single tablets or jarred liquid will not be administered and will therefore be sent home.

-Medication in any amount exceeding the dosage indicated on the bottle.

Medicine	Route(oral? topical?)	Dose	Time	Refrigeration
1.) _____	_____	_____	_____	<input type="checkbox"/> am <input type="checkbox"/> pm <input type="checkbox"/> yes <input type="checkbox"/> no
2.) _____	_____	_____	_____	<input type="checkbox"/> am <input type="checkbox"/> pm <input type="checkbox"/> yes <input type="checkbox"/> no
3.) _____	_____	_____	_____	<input type="checkbox"/> am <input type="checkbox"/> pm <input type="checkbox"/> yes <input type="checkbox"/> no
4.) _____	_____	_____	_____	<input type="checkbox"/> am <input type="checkbox"/> pm <input type="checkbox"/> yes <input type="checkbox"/> no

Special Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any difficulty taking medicines? Y N

If yes, please describe:

\_\_\_\_\_

*I hereby authorize Tyngsboro Sports Center to administer the following medications to my child, in accordance with the Board of Health Regulations 105 CMR 430. 160.*

\_\_\_\_\_  
Parent/Guardian Signature Print Name Date Signed



## PARENT PACKET SUMMER AND VACATION CAMPS

### Board Health Regulations for Administering Medication During Camp Hours

#### **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. The health care consultant shall acknowledge in writing the list of medications administered at the camp. If the health care supervisor is not a licensed health care professional authorized to administer prescription medications, the administrations of 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, and there is written permission from the parent/guardian.

#### **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 Care 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.*

### SUNSCREEN AUTHORIZATION

(Sunscreen Brought from Home)

I, \_\_\_\_\_ (please print full name), authorize the Tyngsboro Sports Center Staff to apply on my child a Sunscreen Lotion provided from home.

Child's Name: \_\_\_\_\_ Child's Age: \_\_\_\_\_

Name of the Sunscreen Lotion provided: \_\_\_\_\_

Possible side Effects (include previous sunscreen reactions):  
\_\_\_\_\_

Reason for application: Protecting from sun. Amount to be given: Cover exposed areas of skin.

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_



# PARENT PACKET SUMMER AND VACATION CAMPS

## HAND SANITIZER AUTHORIZATION

I authorize my child to utilize hand sanitizer while at the Tyngsboro Sports Center. If I prefer that my child uses a certain type, I will send the hand sanitizer to the Tyngsboro Sports Center with my child each day.

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**The following section is not required by TSC, but would help us better understand your camper and their needs. This will be a confidential form and will be used as a helpful guide for counselors to get to know your child better.**

Camper's Name: \_\_\_\_\_ Age: \_\_\_\_\_

School: \_\_\_\_\_ Grade entering in the fall: \_\_\_\_\_

Is this your child's first summer at TYNGSBORO SPORTS CENTER? YES NO

Has your child ever attended any other camps or summer programs? YES NO

### **Camper's Personality:**

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### **Sociability:**

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### **Interests:**

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### **Dislikes and apprehensions? What may cause ambivalence, anxiety, or resistance?**

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### **Talents or passions:**

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**Special needs: Any social, emotional, or psychological issues that may require special attention from staff and camp? Are there any support programs such as IEP that your child is on?**

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# PARENT PACKET SUMMER AND VACATION CAMPS

## Grades Kindergarten – 6

In ungraded classrooms, Kindergarten requirements apply to all students ≥5 years.

DTaP	<b>5 doses</b> ; 4 doses are acceptable if the 4 <sup>th</sup> dose is given on or after the 4 <sup>th</sup> birthday. DT is only acceptable with a letter stating a medical contraindication to DTaP.
Polio	<b>4 doses</b> ; 4 <sup>th</sup> dose must be given on or after the 4 <sup>th</sup> birthday and ≥6 months after the previous dose, or a 5 <sup>th</sup> dose is required. 3 doses are acceptable if the 3 <sup>rd</sup> dose is given on or after the 4 <sup>th</sup> birthday and ≥6 months after the previous dose.
Hepatitis B	<b>3 doses</b> ; laboratory evidence of immunity acceptable
MMR	<b>2 doses</b> ; first dose must be given on or after the 1 <sup>st</sup> birthday and the 2 <sup>nd</sup> dose must be given ≥28 days after dose 1; laboratory evidence of immunity acceptable
Varicella	<b>2 doses</b> ; first dose must be given on or after the 1 <sup>st</sup> birthday and 2 <sup>nd</sup> dose must be given ≥28 days after dose 1; a reliable history of chickenpox* or laboratory evidence of immunity acceptable

## Grades 7 – 12

In ungraded classrooms, Grade 7 requirements apply to all students ≥12 years.

Tdap	<b>1 dose</b> ; and history of DTaP primary series or age-appropriate catch-up vaccination. Tdap given at ≥7 years may be counted, but a dose at age 11-12 is recommended if Tdap was given earlier as part of a catch-up schedule. Td should be given if it has been ≥10 years since Tdap.
Polio	<b>4 doses</b> ; 4 <sup>th</sup> dose must be given on or after the 4 <sup>th</sup> birthday and ≥6 months after the previous dose, or a 5 <sup>th</sup> dose is required. 3 doses are acceptable if the 3 <sup>rd</sup> dose is given on or after the 4 <sup>th</sup> birthday and ≥6 months after the previous dose.
Hepatitis B	<b>3 doses</b> ; laboratory evidence of immunity acceptable. 2 doses of HepB given on or after 18 years of age are acceptable.
MMR	<b>2 doses</b> ; first dose must be given on or after the 1 <sup>st</sup> birthday and the 2 <sup>nd</sup> dose must be given ≥28 days after dose 1; laboratory evidence of immunity acceptable
Varicella	<b>2 doses</b> ; first dose must be given on or after the 1 <sup>st</sup> birthday and 2 <sup>nd</sup> dose must be given ≥28 days after dose 1; a reliable history of chickenpox* or laboratory evidence of immunity acceptable

## Campers, staff and volunteers 18 years of age and older

MMR	<b>2 doses</b> , anyone born in or after 1957. 1 dose, anyone born before 1957 outside the U.S. Anyone born in the U.S. before 1957 is considered immune. Laboratory evidence of immunity to measles, mumps and rubella is acceptable
Varicella	<b>2 doses</b> , anyone born in or after 1980 in the U.S., and anyone born outside the U.S. Anyone born before 1980 in the U.S. is considered immune. A reliable history of chickenpox or laboratory evidence of immunity is acceptable
Tdap	<b>1 dose</b> ; and history of DTaP primary series or age-appropriate catch-up vaccination. Tdap given at ≥7 years may be counted, but a dose at age 11-12 is recommended if Tdap was given earlier as part of a catch-up schedule; Td should be given if it has been ≥ 10 years since Tdap
Hepatitis B	<b>3 doses (or 2 doses of HepB)</b> for staff whose responsibilities include first aid; laboratory evidence of immunity is acceptable

\*A reliable history of chickenpox includes a diagnosis of chickenpox, or interpretation of parent/guardian description of chickenpox, by a physician, nurse practitioner, physician assistant or designee.