CUB SCOUT Summer Camp

Weird Science

Day Camp | Cub Scout Resident Camp | Webelos Resident Camp

Housatonic Council Day Camp and Edmund D. Strang Scout Reservation are Nationally Accredited Cub Scout and Webelos Day and Resident Camps operated by Housatonic Council, BSA.

HOUSATONIC COUNCIL, B.S.A. 111 New Haven Ave Derby, Connecticut
Dear Scouts, Families and Friends,

Thank you to all our youth and adult leadership for the continued perseverance with providing program opportunities to Housatonic Council Cub Scouts during these current times. Thank you to our parents and guardians for your continued support of the Housatonic Council and for your ongoing encouragement to your sons and daughters to keep scouting in their lives even under very difficult circumstances.

In 2021, we look ahead with optimistic anticipation to a new scouting year. We maintain optimism with the realization there are more hurdles to clear in the months ahead. As challenges, new or old are presented, the Housatonic Council will persevere, and we will continue to meet them.

As I write this letter, we are planning and anticipate holding our Cub Scout summer camp programs. On behalf of myself and the entire summer camp staff, welcome!

We are excited to return to the Huntington Chapel, located in Shelton, CT. Our day camp is a Nationally Accredited Camp by the Boy Scouts of America and meets all standards set forth by the National Office of the Boy Scouts of America for the operation of a Cub Scout Day or Resident Camp. Housatonic Council Day Camp and Resident Camp is open to youth ranging from current Lions to Webelos (ages 5 - 11).

If you are interested in an overnight resident camp (sleep-away) try Camp Strang, at Camp Strang your whole family can participate. Located in the foothills of Litchfield County. Camp Strang is 184 acres of forest, fields and streams provide the backdrop to an exciting scouting experience.

Camping is a great scouting experience that every youth should experience. This is where their resourcefulness and self-reliance grow, where the outdoors become a lifelong source of recreation. A place youth will learn a lot and have fun! We hope your family will join us this summer for the adventure of a lifetime.

Yours in Scouting,

Gary Parker
Council President
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DIRECTIONS TO CAMP

CUB SCOUT DAY CAMP
HUNTINGTON CHAPEL, SHELTON, CT
177 Ripton Road, Shelton, CT
(Directions from the Housatonic Council Service Center)
• Turn left onto Main St/CT-34.
• Turn left onto Bridge St.
• Take the 1st right onto Howe Ave/CT-110.
• Take the 1st left onto White St/CT-108.
• Take the 1st right onto Perry Ave/CT-108. Continue to follow CT-108.
• Turn slight right onto Ripton Rd.
• 177 Ripton Rd, Shelton, CT 06484-2631, 177 RIPTON RD is on the right.

CUB/WEBELOS RESIDENT CAMP
EDMUND D. STRANG SCOUT RESERVATION, GOSHEN CT
is located on West Side Road in Goshen, CT.
• From the Lower Naugatuck Valley, follow Route 8 North towards Torrington.
• Take Exit 44 onto Route 4 West towards Goshen.
• Follow Route 4 West approximately 6 miles to Goshen.
• At the rotary, take a right onto Route 63 North.
• West Side Road is the first left past St. Thomas Roman Catholic Church.
• Follow West Side Road for approximately one mile. The Main camp entrance will be on the right side of the road past the Caretaker’s house.
• At Camp Strang all vehicles must be parked in the main parking lot.
Camp Information

- Directions .................................................................................................................................................. Page 5
- Cub Scout Day Camp .................................................................................................................................. Pages 7 - 8
- Cub Scout & Webelos Resident Camp ........................................................................................................ Pages 9 - 11
- Cub Scout Day Camp Registration Forms
  - Day Camp Registration Form .................................................................................................................. Page 13
  - Extended Hours Program* ....................................................................................................................... Page 15
- Cub Scout Resident Camp Registration Form .............................................................................................. Page 19
- Medical Forms Needed / Required for Camp
  - Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel ........................................................................................................................................ Pages 21
  - Medical Addendum Required for Camp Strang (week 3 only) ................................................................. Page 23
  - Youth Scouts of America Medical Form ..................................................................................................... Page 25 - 28
- Camp Scholarship Application ...................................................................................................................... Page 29
- Request for Refund ....................................................................................................................................... Page 31
Cub Scout Day Camp

HOUSATONIC COUNCIL DAY CAMP will be held at the Huntington Chapel in Shelton.

CAMP STRANG - Day Camp at Camp Strang will provide roundtrip transportation from the Valley directly to Camp Strang. The camp day runs longer due to this round trip bus transportation (approximately 8am - 5:30pm).

SAFETY IS OUR TOP PRIORITY
Our camps are staffed daily by a certified health officer. Cub Scout Day Camp meets or exceeds National BSA Camp Standards and Complies with Connecticut State Law for youth camps.

INSURANCE
Housatonic Council provides secondary health and accident insurance for participants, which covers costs not paid by the primary carrier. Non-Housatonic Council participants need to provide proof of council/unit insurance.

VISITORS
All visitors must sign in and out at camp headquarters.

Cub Scout Day Camp schedule for 2021

Week 1 July 19 to July 23
LOCATION: Huntington Chapel
RANKS: Lions - Webelos
SPECIAL: Field Trip included in the fee!

Week 2 July 26 to July 30
LOCATION: Huntington Chapel
RANKS: Lions - Webelos
SPECIAL: Field Trip to Camp Strang included in the fee!

Week 3 August 2 to August 6
LOCATION: Camp Strang
RANKS: Lions - Webelos
SPECIAL: Daily bus transportation and daily lunch included in camp fee!

Cub Scout Day Camp is an organized summer program. Campers participate in a rotating variety of activities.

TRANSPORTATION IS PROVIDED TO CAMP STRANG
Round trip transportation will be provided to Camp Strang.

Leaving at 8am.
Return drop-off will be at approximately 5:30pm.
WHAT TO PACK
- Swim Suit
- Towel
- Swimming Shoes
- Sneakers
- Canteen or Water Bottle
- Sweatshirt or Jacket
- Extra shorts/pants/t-shirt/socks
- Bug Repellent (non-aerosol)
- Sun Screen

LUNCH
A healthy lunch and snack must be brought from home daily to Huntington Chapel.

AT CAMP STRANG, a healthy snack and lunch will be provided in the dining hall (included in your camp fee).

REQUIRED MEDICAL FORMS
All cub scouts and adult volunteers are required to submit their medical form prior to the start of camp.

MAKE COPIES!!! Health forms will not be returned, per state law. No medical examinations can be given at camp.

CAMP TRADING POST
The camp trading post will be open each day offering a variety of snacks, treats, scout items, and small toys for purchase.

MEDICATIONS
All medications for scouts and adults needed while at camp must be turned into the health officer during check-in. Each form of medication must have a date as well as a doctor’s name on the container. Medications must be in the original container with an attached photo! Non-prescription medication also.

**Medications must be picked up prior to leaving camp at the end of the week. All medications left behind are destroyed two weeks after the end of camp.**
Cub Scout & Webelos Resident Camp

CUB RESIDENT PROGRAM
The program provides a fun and educational experience for youths. Each Pack is assigned to a campsite together with Pack leaders. The Pack stays together all day for the duration of your stay as they follow a structured program. This program will run alongside the Webelos Resident Camp program starting on Wednesday morning and concluding Saturday morning.

CUB SCOUT LEADERSHIP POLICY
PARENTS OF PARTICIPANTS ARE STRONGLY ENCOURAGED TO ATTEND! It is the policy of the Boy Scouts of America that at least 2 adult leaders, one of whom must be 21 years of age or older, are required for camping as a unit. Camp Strang works with Packs to combine Leadership when needed. Camp Strang maintains a 5 to 1 ratio during Cub/Webelos week.
Volunteer leaders are responsible for a group of youths during the week. Parents are asked to pass along any pertinent information to the Leader during check-in to help ensure that the Leader is prepared to give each camper the best experience possible.

WEBELOS RESIDENT PROGRAM
Similar to the Cub Resident Program, the Webelos Program is centered around fun and educational experiences for youth. Each Pack is assigned to a campsite together with Pack leaders. The Pack stays together for the duration of your stay as they follow a structured program. Afternoon activities may vary. Participants will see all program areas in camp.

WEBELOS LEADERSHIP POLICY
PARENTS OF PARTICIPANTS NEED NOT ATTEND. Each Pack is asked to send at least two leaders. Camp Strang staff will work with Packs to combine leadership when needed. All adults staying in camp must bring their Youth Protection training certificate! It is the policy of the Boy Scouts of America that at least 2 adult leaders, one of whom must be 21 years of age or older, are required for all camping. Camp Strang works with Packs to combine Leadership when needed. Camp Strang maintains a 5-to-1 ratio during Webelos week. Volunteer Pack leaders are responsible for a group of youths during the week. Parents are asked to pass along any pertinent information to the Pack Leader during check-in to help ensure that the Pack Leader is prepared to give each camper the best experience possible. Some pack leaders choose to split the week.
Cub Scout and Webelos Resident Camp is an organized program for ALL Cub Scouts. It is conducted at the Edmund D. Strang Scout Reservation. Activities include, Ga-ga Ball, swimming, canoeing sports, archery, nature, & more. It’s safe and fun for everyone. Resident camp is the camp that youths come to for the adventure of a lifetime. Don’t miss it!

**WHAT TO PACK**

- Swimming Suit
- Towel
- Sneakers
- Water Bottle
- Clothing for # of Days
- Sweatshirt or Jacket
- Socks
- Pajamas
- Undergarments
- Sleeping Bag
- Pillow
- Foot Locker (recommended)

- Bug Repellent (non-aerosol)
- Sun Screen
- Soap
- Shampoo/Conditioner
- Toothpaste & Brush, Floss
- Flashlight
- Insect Netting & Poles
- Flashlight
- Pocketknife and Whittling Chip Card

**DO NOT PACK:**

- Electronics
- Food
“Keep close to Nature’s heart...and break clear away, once in a while, and climb a mountain or spend a week in the woods. Wash your spirit clean. None of Nature’s landscapes are ugly so long as they are wild.” – John Muir

Gear up for a FUN and EXCITING program where Scouts work towards requirements for the CUB SCOUT 2021 - 2022 program year... Youths will bring home an advancement sheet of what they accomplished.

CHECK-IN PROCEDURE
Parents are to check-in scouts at the check-in area Tierney Building (STEM CENTER) between 2:00 PM - 3:00 PM.

Cub Scouts are to arrive with bathing suits on for swim tests. Once Packs are assembled, pack leaders may escort their packs to the waterfront beginning at 2:30 PM.

CHECK-OUT PROCEDURE
Parents are welcome to arrive Saturday morning for breakfast (need to have meal ticket) beginning at 8:00 A.M. There will be a closing ceremony immediately following breakfast. Scouts will be dismissed to their parents following the closing at approximately 9:30 A.M.

TYPICAL DAY AT CAMP STRANG

6:30 - Polar Bear Swim
8:00 - Breakfast
9:00-12:00 - Morning Activities
12:30 - Lunch
1:00 - Siesta
2:00-4:00 - Afternoon Activities
4:00 - 5:00 Free Swim
6:00 - Dinner
7:00-8:00 - Evening Activities
8:00 - Campfires in sites
9:30 - Lights out
### 2021 CUB SCOUT DAY CAMP REGISTRATION FORM

$25 deposit per Camper due by June 1, 2021. **After June 1, 2021 add $25 per week**

<table>
<thead>
<tr>
<th>Pack No.</th>
<th>Parent Last Name</th>
<th>Parent First Name</th>
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<th>Address</th>
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<th>Home Phone Number</th>
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<th>Email Address</th>
<th>Parent Signature</th>
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### AVAILABLE WEEKS OF CAMP

**WEEK 1**
- Monday, July 19 - Friday, July 23
- Huntington Chapel
- Field Trip to Camp Strang

**WEEK 2**
- Monday, July 26 - Friday, July 30
- Huntington Chapel
- Field Trip to Camp Strang

**WEEK 3**
- Monday, August 2 - Friday, August 6
- Camp Strang, Goshen, CT
- Daily Bus Transportation Provided

### Select Weeks for Campers in the Family

1st Camper’s Name | Date of Birth | Rank as of Sept. 2021 | [ ] Week 1 | [ ] Week 2 | [ ] Week 3
--- | --- | --- | --- | --- | ---

T-Shirt Size: YM YL YXL

2nd Camper’s Name | Date of Birth | Rank as of Sept. 2021 | [ ] Week 1 | [ ] Week 2 | [ ] Week 3
--- | --- | --- | --- | --- | ---

T-Shirt Size: YM YL YXL

### Fees:
For 1st Overall week $225, for second overall week $175, all additional weeks $125 each

Example: (2 attend camp for 2 weeks: $225 + $175 + $125 + $125 = $650)

**Make checks payable to:** Housatonic Council, BSA

**Total:**

**Deposit of $25 per week per person due by June 1, 2021**

**Late Charge of $25 per week per person if signing up after June 1, 2021**

### Payment by Cash or Check

- **Amount Enclosed:** $
- **Date:**
- **Check #:**

### Credit Card Payment

- **Credit Type:** (check one) [ ] MC [ ] VISA
- **Name of Card Holder:**
- **Acct#:**
- **Exp. Date:**
- **Sec # on back:**
- **Signature:**

**Remit to:** Housatonic Council, BSA; 111 New Haven Avenue, Derby CT 06418

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**REFUND POLICY** (Page 31) >> THERE IS NO REFUND FOR MISSED DAYS. Each session requires a $25 non-refundable deposit per week. **ALL REFUND REQUEST MUST BE MADE IN WRITING TO THE COUNCIL SERVICE CENTER BY AUGUST 31, 2021.**
Cub Scout Day Camp

EXTENDED HOURS PROGRAM

We offer early morning drop off starting at 7:30 a.m. and extended afternoon hours until 5:30 p.m. During this time, campers enjoy a variety of different activities and programming.

EXTENDED HOURS REGISTRATION FORM

Scout(s) Name(s) ___________________________________________ Pack # ______

Parent(s) Name ______________________________________________

Address ______________________________________________________

City ___________________ State ________ Zip ______________

Home # _________________________ Cell # ______________________

EXTENDED HOURS SCHEDULES AND FEES

Before-Camp Extended Hours run from 7:30 a.m. - 9:00 a.m. After-Camp extended hours run from 4:00 p.m. until 5:30 p.m. Make your selection from the schedules below and multiply the total number of sessions used by $10.00 each.

☐ WEEK 1 - BEFORE-CAMP SCHEDULE

<table>
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<tr>
<th>MON</th>
<th>TUE</th>
<th>WED</th>
<th>THU</th>
<th>FRI</th>
<th>#DAYS</th>
<th>X $10/EA.</th>
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☐ WEEK 1 - AFTER-CAMP SCHEDULE

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<th>FRI</th>
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☐ WEEK 2 - BEFORE-CAMP SCHEDULE

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<th>MON</th>
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<th>FRI</th>
<th>#DAYS</th>
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☐ WEEK 2 - AFTER-CAMP SCHEDULE

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<th>FRI</th>
<th>#DAYS</th>
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TOTAL # OF SESSIONS (Before & After): __________ x $10 PER SESSION = TOTAL PAID: __________

For Office Use Only: Medical and Medication Form attached: Y  N   Receipt #: __________
Resident Camp at Strang
REGISTRATION FORM

Name: __________________________________ Age:_______  Birth date: ____ / ___ / ____
Address: ___________________________________ Town: _______________ State: _____ Zip:_________
Phone: _______________________________ Unit #:________ Unit’s Town: __________________________
School Name:_________________________________________ Town_________________________________

Rank as of September 2021:   Lion   Tiger   Wolf   Bear   Webelos I   Webelos 2

Name of Adult Attending Camp with Scout: ____________________________________________
Parents Signature (Required): _________________________________________________________________

CUB SCOUT and WEBELOS RESIDENT CAMP AT CAMP STRANG
The following prices are the rates for one and half-week sessions at Camp Strang. Check the appropriate week(s) you will attend and circle the fee amount (s) per your payment date. Camp rate includes a $25 non-refundable deposit.

<table>
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<tr>
<th>SESSION</th>
<th>CAMP SESSION</th>
<th>CAMP RATE</th>
<th>EARLY BIRD</th>
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<tr>
<td>#1</td>
<td>CUB &amp; WEBELOS RESIDENT CAMP: Adults and Cubs (One Parent attends Free with each Cub Scout) Sunday, August 1st - Wednesday, August 4th</td>
<td>$235</td>
<td>$215</td>
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<tr>
<td>#2</td>
<td>CUB &amp; WEBELOS RESIDENT CAMP: Adults and Cubs (One Parent attends Free with each Cub Scout) Wednesday, August 4th - Saturday, August 7th</td>
<td>$235</td>
<td>$215</td>
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<td>DEN CHIEF &amp; Additional Attendees / Per Session</td>
<td>$130</td>
<td>$115</td>
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Total All Above $___________ Campership $___________

Pack or Troop Paying $_________  
Total Payment Amount Due: ____________________________

OFFICE USE ONLY:
Camp Week: _____ Amount paid: ________________ Verified by:__________________ Amount of refund:__________
Authorized by:___________________________
Each medication to be administered by the health officer will need to have the Authorization for the Administration of Medication by School. Child Care, and Youth Camp Personnel form completed, filled out and signed by a doctor for each medication to be administered including any over the counter vitamins, inhalers and EpiPens.

If this form is not completed – the medication cannot be administrated.

PLEASE NOTE***

- Camp Medical
- Medical Form Addendum
- Authorization for the Administration of Medications

Should be brought to camp and not the Council Office and turned in at check in.
Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, ChildCare Centers and Group Care Homes, licensed Family Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber’s Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student: _______________________________ Date of Birth ___/___/____ Today’s Date ___/___/____

Address of Child/Student: _______________________________ Town __________________________

Medication Name/Generic Name of Drug, ____________________________________________ Controlled Drug? □ YES □ NO

Condition for which drug is being administered: ____________________________________________

Specific Instructions for Medication Administration ____________________________________________

Dosage ____________________________________________ Method /Route, ____________________________________________

Time of Administration ______________________________ If PRN, frequency ______________________________

Medication shall be administered: Start Date: _____ / _____ / _____ End Date: _____ / _____ / _____

Relevant Side Effects of Medication ____________________________________________ □None Expected

Explain any allergies, reaction to/negative interaction with food or drugs, ____________________________________________

Plan of Management for Side Effects ____________________________________________

Prescriber’s Name / Title ____________________________________________ Phone Number (____) _____________

Prescriber’s Address ____________________________________________ Town __________________________

Prescriber’s Signature ____________________________________________ Date _____ / _____ / _____

School Nurse Signature (if applicable) ____________________________________________

Parent/Guardian Authorization:

□ I request that medication be administered to my child/student as described and directed above

□ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of their medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only)

□ I have administered at least one does of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent /Guardian Signature_________________________________ Relationship____________________ Date _____ / _____ / _____

Parent /Guardian’s Address ____________________________________________ Town __________________________ State _____

Home Phone # (____) ______ · __________ Work Phone # (____) ______ · __________ Cell Phone # (____) ______ · __________

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student’s parent or guardian or eligible student.

Prescriber’s authorization for self-administration: □ YES □ NO ____________________________________________

Signature Date ____________________________________________

Parent/Guardian authorization for self-administration: □ YES □ NO ____________________________________________

Signature Date ____________________________________________

School nurse, if applicable, approval for self-administration: □ YES □ NO ____________________________________________

Signature Date ____________________________________________

Today’s Date ____________ Printed Name of Individual Receiving Written Authorization and Medication ____________________________

Title/Position ____________________________________________ Signature (in ink or electronic) ____________________________

Note: Their form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-827a(v.)
MEDICAL ADDENDUM
REQUIRED FORM

to attend Camp Strang!

(must be completed by parent/guardian for scouts under 18 years old)

Scout____________________________   Pack _____ Week (s) ________

This addendum to the Annual BSA Health and Medical Record is for scouts under 18 years of age and is required to meet Connecticut Department of Health requirements.

I give my permission for the camp Health Officer/Nurse to administer over-the-counter medications as directed by the Camp Physician in the Camp Standing Orders. The Housatonic Council’s policies on medications at scout camp are written to comply with the National Standards of the Youth Scouts of America and the State of Connecticut Health Department.

If you do not wish to have any of the following over-the-counter medications administered, please cross out and initial.

Over-the-Counter Medications may include:

(Generics may be substituted)

- Tylenol by mouth, per weight/age dosing as needed every 4-6 hours
- Advil by mouth, per weight/age dosing as needed every 6-8 hours
- Bacitracin/Neosporin/Hydrogen Peroxide topically as needed
- Hydrocortisone Cream topically every 6 hours as needed
- Benadryl by mouth, per weight/age dosing as needed, per package directions
- Claritin by mouth, per package directions
- Sudafed by mouth, per package directions
- Zantac by mouth, per package directions
- Sunscreen topically, as needed
- Bug repellent topically, as needed every 2-4 hours
- Solarcaine/Aloe Vera topically as needed every 2-4 hours

Signature____________________________   Date___________

**REMINDER** - Prescription medications must be in the original pharmacy container with label, this includes EPI-Pens. Please bring only amount needed for camp. Failure to comply will result in the inability for the medications to be administered at camp. Any medication not picked up within 1 week after scout leaves camp will be destroyed.
2021 Event Screening

Review with each youth and adult participant their current health status, both before departure and upon arrival at the event. **Anyone entering a camp or event – including visitors, vendors, etc. – must be screened.**

Attendee’s Full Name: 

Age _______ Unit Type / No. _________ Community: __________________________

Has the Attendee or anyone they have come in contact with arrived or vacationed in an “Affected State” which means a state or territory, other than New York, New Jersey, or Rhode Island; an “Affected Country” means a country other than the United States; and an “Affected Traveler” means a person entering into or returning to the State of Connecticut who has spent twenty-four hours or longer in an Affected State or an Affected Country within ten days prior to arriving in Connecticut, but does not include an individual remaining in Connecticut for less than twenty-four hours.– if yes he or she should stay home.

☐ Yes ☐ No

Have you or has anyone in your household been in close contact* in the past 14 days with anyone known or suspected to have COVID-19 or is otherwise sick?

☐ Yes ☐ No

Have you or has anyone in your household been in close contact* with anyone who has been tested for COVID-19 and is waiting for results?

☐ Yes ☐ No

Have you or has anyone in your household been sick in the past 14 days, or have you or they been tested for any illness and are waiting for results?

☐ Yes ☐ No

Has anyone in your household been exposed to an individual known or suspected to have COVID-19 in the past 14 days?

☐ Yes ☐ No

Have you or has anyone you have been in close contact* with traveled on a cruise ship or internationally or to an area with a known communicable disease outbreak in the past 14 days?

☐ Yes ☐ No
2021 Event Screening

*According to the Centers for Disease Control and Prevention (CDC), “close contact” means:
- You were within 6 feet of someone who has COVID-19 for a cumulative total of 15 minutes or more over a 24-hour period
- You had direct physical contact with an infected person (hugged or kissed them)
- You shared eating or drinking utensils
- An infected person sneezed, coughed, or otherwise got respiratory droplets on you

If the answer is YES to any one of the questions above, the participant must stay home.

Symptoms of COVID-19

If anyone in your household has any one of the following new or worsening signs or symptoms of possible COVID-19, the entire household must stay home.

- Shortness of breath
- Cough
- Fever of 100.0°F or greater
- Flu-like symptoms
- Repeated shaking with chills
- Fatigue
- Muscle or body aches
- Headache
- Sore throat
- Loss of taste or smell
- Diarrhea
- Nausea or vomiting

*Potential Higher-Risk Individuals*

- Yes  □  No  □  Are you in a higher-risk category as defined by the CDC guidelines, including older adults, people with medical conditions, and those with other individual circumstances?

If the answer is “yes,” we recommend that you stay home.

Should you choose to participate, you must have approval from your health care provider.

Does the Attendee have any Covid-19 high risk factors:

- Pulmonary Issues: Asthma, COPD, lung disease, other
- Heart Conditions
- Immunosuppressed
- Kidney or Liver Issues
- Diabetes
- Over 65 years old
- Other known high-risk factors: __________________________

It is highly recommended anyone with any Covid-19 high risk factor not attend.
2021 Event Screening

I understand the importance of social distancing and taking extra precautions to protect all attendees during the Covid-19 pandemic. I understand the risks of attending an event and acknowledge I may contract Covid-19 during travel to and from, or during the event itself, regardless of the extra precautions the Housatonic Council, my unit, and myself have taken.

Attendee Signature (Parent/Guardian’s Signature if Attendee is Minor)

_________________________________________ Date: __________________________

_________________________________________

Attendee Signature verifying temperatures (parent/guardian if a minor)

_________________________________________ Date __________________________

This section to be completed by Health Officer

☐ Review first half of this pre-screening questionnaire and discuss issues.
☐ Review Covid-19 social distancing guidelines.
☐ Verify Attendee has a face covering.

Health Officer Signature: ________________________________ Date ________________
Part A: Informed Consent, Release Agreement, and Authorization

Full name: ________________________________
Date of birth: ______________________________

Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the troop, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physicians or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§164.501, 164.502, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risks involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA employees or volunteers who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videos/tapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videos/tapes/electronic representations and/or sound recordings without limitation at the discretion of the BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

Every person who furnishes any BB device to any minor, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 198.5(e)(6))

My signature below on this form indicates my permission.

☐ Checking this box indicates you DO NOT want your child to use a BB device.

NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.

List participant restrictions, if any: □ None

I understand that, if any information I’ve provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Philmont Scout Ranch, Philmont Training Center, Northern Tier, Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: ____________________________ Date: ____________________________
Parent/guardian signature for youth: ____________________________ Date: ____________________________

Complete this section for youth participants only:

Adults Authorized to Take Youth to and From Events:

You must designate at least one adult. Please include a phone number.

Name: ____________________________ Phone: ____________________________

Name: ____________________________ Phone: ____________________________

Adults NOT Authorized to Take Youth to and From Events:

Name: ____________________________ Phone: ____________________________

Name: ____________________________ Phone: ____________________________
### Part B1: General Information/Health History

**Full name:**

**Date of birth:**

**Age:**

**Gender:**

**Height (inches):**

**Weight (lbs):**

**Address:**

**City:**

**State:**

**ZIP code:**

**Phone:**

**Unit leader:**

**Unit leader’s mobile #:**

**Council Name/No.:**

**Unit No.:**

**Health/Accident Insurance Company:**

**Policy No.:**

⚠️ Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.

### In case of emergency, notify the person below:

**Name:**

**Relationship:**

**Address:**

**Home phone:**

**Other phone:**

**Alternate contact name:**

**Alternate's phone:**

### Health History

Do you currently have or have you ever been treated for any of the following?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Diabetes (high blood pressure)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hypertension or congestive heart disease/heart attack/cholesterol problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heart murmurs or coronary artery disease. Any heart surgery or procedure.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family history of heart disease or any sudden heart-related death of a family member before age 50</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stroke/TIA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Asthma/reactive airway disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lung/respiratory disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>COPD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ear/eyes/nose/throat problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Muscular/skeletal condition/muscle or bone issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Head injury/concussion/TBI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Altitude sickness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychiatric/psychological or emotional difficulties</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neurological/behavioral disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blood disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sicca syndrome or diabetes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kidney disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seizures or epilepsy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Abdominal/stomach/digestive problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thyroid disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Skin issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Obstructive sleep apnea/sleep disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPAP: Yes No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>List all surgeries and hospitalizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Last surgery date:</td>
</tr>
</tbody>
</table>

*List any other medical conditions not covered above*
Part B2: General Information/Health History

Full name: ________________________________

Date of birth: ________________________________

High-adventure base participants:
Expedition/crew No.: ________________________________
or staff position: ________________________________

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? Exp. date (if yes) _____

☐ YES ☐ NO

DO YOU USE AN ASTHMA RESCUE INHALER? Exp. date (if yes) _____

☐ YES ☐ NO

Are you allergic to or do you have any adverse reaction to any of the following?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Allergies or Reactions</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Medication</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Food</td>
<td></td>
</tr>
</tbody>
</table>

List all medications currently used, including any over-the-counter medications.

☐ Check here if no medications are routinely taken. ☐ If additional space is needed, please list on a separate sheet and attach.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ YES ☐ NO Non-prescription medication administration is authorized with these exceptions: ________________________________________________________________

Administration of the above medications is approved for youth by: ________________

Parent/guardian signature: ____________________________

MD/DO, NP, or PA signature (if your state requires a signature): ____________________________

!! Bring enough medications in sufficient quantities and in the original containers. Make sure they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor. !!

Immunization

The following immunizations are recommended. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Had Disease</th>
<th>Immunization</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Tetanus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Pertussis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Diphtheria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Measles/mumps/rubella</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Polio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Chicken Pox</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Hepatitis A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Hepatitis B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Meningitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Influenza</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Other (i.e., Hib)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Exemption to immunizations (form required)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please list any additional information about your medical history: ________________________________________________________________

DO NOT WRITE IN THIS BOX.
Review for camp or special activity.
Reviewed by: ____________________________
Date: ____________________________
Further approval required: ☐ Yes ☐ No
Reason: ____________________________
Approved by: ____________________________
Date: ____________________________
# Part C: Pre-Participation Physical

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

**Full name:**

**Date of birth:**

---

**High-adventure base participants:**

Expedition/crew No.:

or staff position:

---

You are being asked to certify that this individual has no contraindications for participation in a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patrol. You can also visit [www.scouting.org/health-and-safety/ahmr](http://www.scouting.org/health-and-safety/ahmr) to view this information online.

---

**Medical restrictions to participate**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

---

**Allergies or Reactions**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Medication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Food</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Insect bites/stings</td>
</tr>
</tbody>
</table>

---

**Height (inches)**

**Weight (lbs.)**

**BMI**

**Blood Pressure**

**Pulse**

---

**Examiner's Certification**

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions):

<table>
<thead>
<tr>
<th>True</th>
<th>False</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Meets height/weight requirements.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Has no uncontrolled heart disease, lung disease, or hypertension.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Has no uncontrolled psychiatric disorder.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Has had no seizures in the last year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Does not have poorly controlled diabetes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If planning to scuba dive, does not have diabetes, asthma, or seizures.</td>
</tr>
</tbody>
</table>

Examiner's signature: ___________  Date: ___________

Examiner's printed name: ___________

Address: ___________

City: ___________  State: ___________  ZIP code: ___________

Office phone: ___________

---

**Height/Weight Restrictions**

If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

**Maximum weight for height:**

<table>
<thead>
<tr>
<th>Height (inches)</th>
<th>Max. Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>166</td>
</tr>
<tr>
<td>41</td>
<td>172</td>
</tr>
<tr>
<td>42</td>
<td>178</td>
</tr>
<tr>
<td>43</td>
<td>183</td>
</tr>
<tr>
<td>44</td>
<td>189</td>
</tr>
<tr>
<td>45</td>
<td>195</td>
</tr>
<tr>
<td>46</td>
<td>201</td>
</tr>
<tr>
<td>47</td>
<td>207</td>
</tr>
<tr>
<td>48</td>
<td>213</td>
</tr>
<tr>
<td>49</td>
<td>220</td>
</tr>
</tbody>
</table>

---

**Height (inches) | Max. Weight**

| 70             | 236         |
| 71             | 243         |
| 72             | 250         |
| 73             | 256         |
| 74             | 262         |
| 75             | 269         |
| 76             | 276         |
| 77             | 284         |
| 78             | 291         |

---

**Height (inches) | Max. Weight**

| 79 and over    | 295         |

---

Prepared. For Life.
CAMP SCHOLARSHIP FUND APPLICATION

Name: _________________________________ Age (as of 7/1/2021) ________________________________
Address: ______________________________ City ___________________ State ______ Zip _________
Telephone: _____________________________ Unit: Pack Troop Crew (circle one) #___________________
Parent – Briefly explain your need for campership assistance:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
This youth is planning on attending __________________ week (s) of camp.
Applying for:  ❑ Webelos Resident Camp  ❑ Cub Scout Resident Camp
              ❑ Cub Scout Day Camp week of ______________
I can afford to pay the following $ __________________ towards my child’s week (s) at camp.
Number of persons in household ______
Gross Income $_____________
Documentation needed for Campership.
  $25 non refundable deposit needed to process their campership application
  Do you qualify for AFDC___ State Aid___ Social Security___ Lunch Program ____
  I understand that this is an application, and in no way guarantees a camp scholarship. I further understand that
  Housatonic Council awards partial camp scholarship and that scouts are encouraged to earn part of their camp fee.
  This is limited to Housatonic Council Camp facilities.

Parents Name (please print) __________________________________________________________________
Address:  _______________________________________City ___________________ State ____ Zip ______
Parents Signature: _________________________________________________________________________

Mail to: Camperships Committee, Housatonic Council BSA, 111 New Haven Avenue, Derby, Connecticut, 06418

This applicant is a registered scout within my unit.

Unit Leader’s Signature: ______________________________________________ Date: ____________

Service Center Use Only
Date Received in Office ______________________
Amount paid $__________________ Amount awarded $____________ Amount due$ ________
  ❑ Council Campership Fund  ❑ Fresh Air Fund  ❑ Confirmation letter sent
THIS PAGE LEFT INTENTIONALLY BLANK
REQUEST FOR REFUND
Housatonic Council, BSA

Refund Policy for Housatonic Council

All requests must be received by August 31ST and must have the Unit Leader’s approval (signature) to be considered for refund. If a Scout will be missing days during a Camp period, that Scout needs to notify the Camp Director at check in time. No refund will include the non-refundable $25.00 deposit.

The only circumstances under which refunds will be granted are as follows:

1. Illness of Scout prevents their attendance at summer camp
2. Illness or death in the campers’ immediate family prevents their attendance at camp
3. Family relocation making attending camp impractical
4. Mandatory attendance at summer school that is verifiable
5. A Scout leaves camp for medical reasons (home sickness is not considered a refundable medical reason) must be certified by the Camp Health Officer or Camp Director. In such cases, the Scout will receive a pro-rated refund for the unused portion of the camp fee. If the unused portion constitutes three or more days and the medical excuse is not due to horseplay or negligence of said Scout.

Absolutely no refunds will be granted for “No Shows” or Days Missed.

Scouts name: _________________________________ Troop/Pack _______________________
Address: _____________________________________ City: ___________________State: ______
Zip: __________________
Parents Name: _____________________________________________
Phone #: ___________________________ Cell Phone: _________________________________
Camp Attending and Date(s): ______________________________________________________
Reason for Refund_______________________________________________________________

Mail to: Housatonic Council, BSA, 111 New Haven Avenue, Derby, CT. 06418
JOIN US THIS SUMMER AT CAMP!

HOUSATONIC COUNCIL, BSA
111 NEW HAVEN AVE,
DERBY, CT 06418
(203)734-3329