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

HOUSATONIC COUNCIL, B.S.A.

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

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.

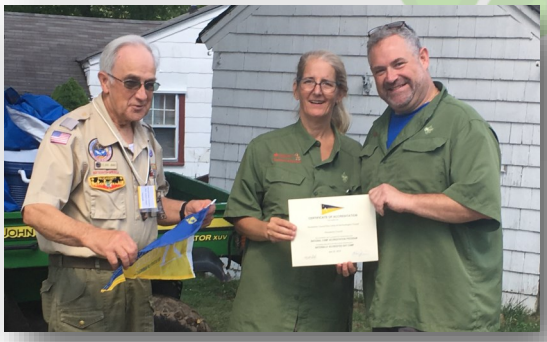
CAMP TRADING POST

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 must be left with the health officer also. This is a state law.

*****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

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2021 CUB SCOUT DAY CAMP REGISTRATION FORM

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

Pack No.	Parent Last Name	Parent First Name
Address	City, State Zip	
Home Phone Number	Cell Phone Number	
Email Address	Parent Signature	Date

AVAILABLE WEEKS OF CAMP

WEEK 1	WEEK 2	WEEK 3
Monday, July 19 - Friday, July 23	Monday, July 26 - Friday, July 30	Monday, August 2 - Friday, August 6
Huntington Chapel	Huntington Chapel	Camp Strang, Goshen, CT
Field Trip to Camp Strang	Field Trip to Camp Strang	Daily Bus Transportation Provided

Select Weeks for Campers in the Family

1st Camper's Name	Date of Birth	❒ Week 1	❒ Week 2	❒ Week 3
T-Shirt Size: YM YL YXL	Rank as of Sept. 2021			
2nd Camper's Name	Date of Birth	❒ Week 1	❒ Week 2	❒ Week 3
T-Shirt Size: YM YL YXL	Rank as of Sept. 2021			

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	**Credit Card Payment**
Amount Enclosed: $	Credit Type: (check one) ❒ MC ❒ VISA
Date: Check #:	Name of Card Holder:
Remit to: Housatonic Council, BSA; 111 New Haven Avenue, Derby CT 06418	Acct#:
	Exp. Date: Sec # on back
	Signature:

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.**

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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**

MON	TUE	WED	THU	FRI	#DAYS	X $10/EA.
						$

❒ **WEEK 1 - AFTER-CAMP SCHEDULE**

MON	TUE	WED	THU	FRI	#DAYS	X $10/EA.
						$

❒ **WEEK 2 - BEFORE-CAMP SCHEDULE**

MON	TUE	WED	THU	FRI	#DAYS	X $10/EA.
						$

❒ **WEEK 2 - AFTER-CAMP SCHEDULE**

MON	TUE	WED	THU	FRI	#DAYS	X $10/EA.
						$

TOTAL # OF SESSIONS (Before & After): _____ x $10 PER SESSION = TOTAL PAID: _____

For Office Use Only: Medical and Medication Form attached: Y N Receipt #: _____

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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.

Please Note*Camp Medical, Medical Form Addendum and Authorization for the Administration of Medications forms should be brought to camp and not the Council Office and turn in at check in.**

SESSION	CAMP SESSION	CAMP RATE	EARLY BIRD
#1	**CUB & WEBELOS RESIDENT CAMP: Adults and Cubs (One Parent attends Free with each Cub Scout)** Sunday, August 1st - Wednesday, August 4th	$235	$215
#2	**CUB & WEBELOS RESIDENT CAMP: Adults and Cubs (One Parent attends Free with each Cub Scout)** Wednesday, August 4th - Saturday, August 7th	$235	$215
	DEN CHIEF & Additional Attendees / Per Session	$130	$115

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:_____

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Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

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.

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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 ttheir 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: Ttheir form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

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MEDICAL ADDENDUM

REQUIRED FORM

to attend Camp Strang!

REQUIRED FORM!

For Youth attending Day Camp week 3 or Resident Camp

To attend Camp Strang, this form must be completed by an adult.

(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 with-in 1 week after scout leaves camp will be destroyed.**

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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 100.0º 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
- ❑ Immunocompromised
- ❑ 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 _____

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Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

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 venue, 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 physician 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. §§160.103, 164.501, 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 risk 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 volunteers or professionals 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/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I 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/videotapes/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 19915[a]) My signature below on this form indicates my permission.

I give permission for my child to use a BB device. (Note: Not all events will include BB devices.)

☐ **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/we have 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: _____

(If participant is under the age of 18)

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: _____ Name: _____

Phone: _____ Phone: _____

Adults NOT Authorized to Take Youth to and From Events:

Name: _____ Name: _____

Phone: _____ Phone: _____

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Part B1: General Information/Health History

B1

Full name: _____

Date of birth: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

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?

Yes	No	Condition	Explain
☐	☐	Diabetes	**Last HbA1c percentage and date:** **Insulin pump: Yes** ☐ **No** ☐
☐	☐	Hypertension (high blood pressure)	
☐	☐	Adult or congenital heart disease/heart attack/chest pain (angina)/ heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
☐	☐	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
☐	☐	Stroke/TIA	
☐	☐	Asthma/reactive airway disease	**Last attack date:**
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion/TBI	
☐	☐	Altitude sickness	
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Neurological/behavioral disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures or epilepsy	**Last seizure date:**
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Skin issues	
☐	☐	Obstructive sleep apnea/sleep disorders	**CPAP: Yes** ☐ **No** ☐
☐	☐	List all surgeries and hospitalizations	**Last surgery date:**
☐	☐	List any other medical conditions not covered above	

Part B2: General Information/Health History

B2

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?

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	

Yes	No	Allergies or Reactions	Explain
☐	☐	Plants	
☐	☐	Insect bites/stings	

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.

Medication	Dose	Frequency	Reason

☐ 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 signature)

Bring enough medications in sufficient quantities and in the original containers. Make sure that 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.

Yes	No	Had Disease	Immunization	Date(s)
☐	☐		Tetanus	
☐	☐		Pertussis	
☐	☐		Diphtheria	
☐	☐		Measles/mumps/rubella	
☐	☐		Polio	
☐	☐		Chicken Pox	
☐	☐		Hepatitis A	
☐	☐		Hepatitis B	
☐	☐		Meningitis	
☐	☐		Influenza	
☐	☐		Other (i.e., HIB)	
☐	☐		Exemption to immunizations **(form required)**	

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: _____

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Part C: Pre-Participation Physical

C

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 contraindication 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 patient. You can also visit www.scouting.org/health-and-safety/ahmr to view this information online.

Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate	☐	☐	

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	

Yes	No	Allergies or Reactions	Explain
☐	☐	Plants	
☐	☐	Insect bites/stings	

Height (inches)	Weight (lbs.)	BMI	Blood Pressure	Pulse
			/	

	Normal	Abnormal	Explain Abnormalities
Eyes	☐	☐	
Ears/nose/throat	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Genitalia/hernia	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Skin issues	☐	☐	
Other	☐	☐	

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):

True	False	Explain
☐	☐	Meets height/weight requirements.
☐	☐	Has no uncontrolled heart disease, lung disease, or hypertension.
☐	☐	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.
☐	☐	Has no uncontrolled psychiatric disorders.
☐	☐	Has had no seizures in the last year.
☐	☐	Does not have poorly controlled diabetes.
☐	☐	If planning to scuba dive, does not have diabetes, asthma, or seizures.

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:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295

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HOUSATONIC COUNCIL BOY SCOUTS OF AMERICA

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 ttheir 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

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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