

February 2009

Dear Friend,

It is hard to imagine that the time has come to begin planning and thinking about camp. Only a few short months ago we spent a fabulous week in Rhode Island providing the opportunity of a lifetime for some very special children with Celiac Sprue Disease. What a week it was. Your willingness to step up to the plate and assist in pulling off this enormous endeavor is greatly appreciated not only by me, but by the countless children and their families that have written notes expressing their gratitude and gratefulness for the opportunity Camp Celiac provided them.

Many of you volunteered in some capacity at past camps. Many of you have expressed an interest in volunteering at Camp Celiac 2009. Whatever the reason, we are thrilled to have you inquire. Camp week is a vigorous week. Held at the site of Camp Aldersgate, a Methodist camp site in N. Scituate, RI, Camp Celiac leases the site to hold this specialty camp. Camp Celiac brings in all of its own volunteer staff, including cabin parents and a full-time registered nurse.

Volunteers are up and at 'em from 6:00 or 7:00 a.m. and generally don't get to bed until at least 10:00 p.m. The days are long and physically and emotionally demanding. But the rewards are great. Making a difference in the life of a child is perhaps the greatest gift you can give, and if you are willing to put yourself to the test, I am sure you will feel a great sense of pride and accomplishment. Each year, over half of our staff returns for another year. Many others would like to return, but commitments such as work and family don't enable them to return.

Camp staff is selected by many things. The most important thing to remember is that each volunteer is considered on a first come first serve system. Returning staff must respond by February 28, 2009 for first consideration. After that time, positions will be opened up to interested new staff. Some staff were disappointed last year when they were not able to return because all of the positions were filled prior to their registering on time. Don't let this happen. If you are considering volunteering, return the registration form promptly. On the top of the registration form, clearly print the word "STAFF". Past staff will be considered first and then recruitment staff for replacements will be sought. All staff attend at no charge. Staff is however, responsible for their own transportation to and from camp and the expenses that may incur. We do make every effort possible to pick up staff at T.F. Green Airport, Providence, RI and bring them to camp if the need arises. Those staff members that must fly in prior to the start of staff training will be able to stay at camp after 7:00 p.m. on Saturday August 8 after 6:00 p.m. No dinner will be served and a continental breakfast will be offered on Sunday morning. All staff must be present by 9:30 a.m. sharp on Sunday, August 9, 2009. Please do not be late.

We look forward to reconnecting with past volunteers, meeting new staff and forming lasting friendships. Thank you for your generous gift of time, patience and support.

Sincerely,  
Tanis E. Collard, Camp Director

**CAMP ALDERSGATE/CAMP CELIAC  
CHILD ABUSE PREVENTION POLICY AND PROCEDURES  
VOLUNTEER DISCLOSURE FORM**

United Methodist Camp Aldersgate/Camp Celiac cares about the children, youth and developmentally disabled who annually attend our summer camp programs. We are committed to ensuring their safety from any type of abuse. Because of our unconditional concern for the safety of all campers, Camp Aldersgate/Camp Celiac is requiring all volunteers and staff in our camping program to complete this disclosure.

Please accept this procedure without insult. While the vast majority of volunteers are free from such abusive behavior, we confess as a church we have never been totally free of those who abuse. If an incident is reported, the Director will immediately begin a preliminary investigation. If the charges are found to have any legitimacy, the proper authorities will be called. Then, depending on the circumstances, the parents of the child may be notified. All staff members (employed and volunteer) will be acquainted with the subject of child abuse and will abide by the guidelines set forth.

- All volunteer staff members, employed staff members and any other personnel working with our campers will sign a statement indicating that they have no past record of abusing a child.
- All staff members are responsible for and legally mandated to report cases of suspected child abuse.
- Any reports of suspected child abuse will be made only to the Director.
- In case of an incident only the Director will speak to the necessary person(s) concerning the incident. Under no circumstances should the incident be discussed with fellow campers, fellow staff members, the news media or any one other than proper authorities.
- Since much of the value of our camping program is due to the caring atmosphere between staff and campers, we still understand the need for appropriate physical gestures of support and love (hug, pat on the back, etc.). Be aware! Use your best judgement on when and where this entirely appropriate action should be used. Remember ALL sexual behavior, both verbal and non-verbal, is entirely inappropriate.
- When with a camper, stay in a public area in view of others.(ie., not in their cabin alone or alone on a walk). Make use of the buddy system. Do not let yourself get into a position which can be misinterpreted.
- Use common sense when dealing with campers. We want you and them to have fun, meaningful experiences at camp. Because of our commitment to campers, we will take any and every action to protect them.

**COMPLETE THE FOLLOWING QUESTIONS BY ANSWERING YES OR NO.  
ELABORATE ON ANY YES QUESTIONS.**

1. Have you ever been convicted of any misdemeanors or felonies?
2. Have you ever been found in any dependency action to have sexually assaulted or exploited any minor, or to have physically abused any minor?
3. Have you ever been found by a court in a domestic relations proceeding to have sexually abused or exploited any minor, or to have physically abused any minor?
4. Have you been convicted of the possession, use, or sale of drugs within the last seven years?
5. Have you been released from incarceration for a conviction of the possession, use or sale of drugs within the last seven years?
6. Within the past six months have you abused alcohol, legal or illegal drugs?
7. Has your driver's license been suspended or revoked within the last seven years?
8. Other than the above matters, is there any fact or circumstance involving you and your background that would call into question your being entrusted with the supervision, guidance and care of young people, vulnerable adults or developmentally disabled persons?

## VOLUNTEER COVENANT

I have read this policy. I agree to live by the understanding that, as a person in authority, it is my responsibility to avoid sexual contact with children, youth, vulnerable adults and developmentally disabled persons in my care, even if one attempts to initiate the contact. I will find alternative ways to discipline campers other than by using corporal punishment, agreeing that under no circumstance will I use hitting or spanking, neck or choke holds, ear or hair pulling, or any other form of corporal punishment. I certify that the information I have provided is true and correct. If it is found that the answers I have given are untrue, I understand that I will be dismissed from my volunteer or employment position.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_

Home Phone: \_\_\_\_\_

**The State of Rhode Island requires a Background Criminal Investigation (BCI) check in order for you to work at Camp Aldersgate/Camp Celiac.**

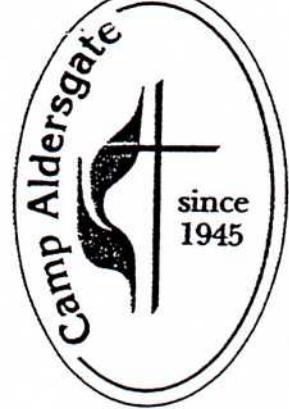
**Please do the following and return to Camp Aldersgate/Camp Celiac.**

- Include a photocopy of your driver's license.
- Get the form (your signature) notarized.
- Mail these to Camp Celiac: Mrs. Tanis Collard  
CSGC  
11 Level Acres Road  
So. Attleboro, MA 02703
- Please do this **TODAY**. The new state law requires we have this on file prior to your arrival.

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A Camp and Retreat Center of the United Methodist Church

## STATE OF RHODE ISLAND BCI REPORT

Name \_\_\_\_\_  
(Print or Type)

D.O.B. \_\_\_\_\_

### DISCLAIMER

I \_\_\_\_\_, request that the Bureau of Criminal Identification of the Department of Attorney General for the state of Rhode Island to make available to me any criminal record that I may have on file with the Bureau of Criminal Identification.

I hereby waive and release any and all manner of actions, cause of actions, and demands of every kind, nature and description, arising from any release of criminal records and requests therefrom, whatsoever against the State of Rhode Island, Bureau of Criminal Identification, the Attorney General, and the employees of the Attorney General's Office in both law and equity which I may now have or in the future may have.

\_\_\_\_\_  
(Signature of Applicant)

Sworn to before me on this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

file:ribci

**ATTENTION ATTORNEY GENERAL'S OFFICE  
PLEASE RETURN ALL BCI INFORMATION  
TO THE ADDRESS BELOW.**

## Waiver Form

The staff members of Camp Celiac make every effort to conduct safe programs, to orient and support children, and to inform families of inherent risks. Some activities may involve risks that children do not routinely encounter at home. Risk management is an essential element of all the activities that we offer. While we anticipate that these efforts will ensure the wellbeing of each child, we are also aware that it is neither possible to foresee every contingency nor to eliminate all risk.

I understand that Camp Celiac program activities may include, but are not limited to:

Horseback riding, low ropes, high ropes, adventure programming, swimming, canoeing, campfires, inflatable carnival equipment (moonwalk, maze, jousting, etc.), portable rock climbing, etc. The newsletter, camp brochure or information packet will inform you of special activities that may also include, but are not limited to, traveling in Camp Celiac's owned or leased vehicles, swimming, kayaking, canoeing, sailing and backpacking. Other risks may be inherent in program activities.

I acknowledge that such risks exist, and I hereby agree on behalf of my child to assume such risks. Further, on behalf of my child, I hereby release and forever discharge, and agree not to sue, and agree to indemnify and hold harmless, Camp Celiac and the Celiac Support Group for Children, Inc. and its respective members, officers, directors, employees and volunteers and each of them, from and against any and all liabilities and obligations of every kind and description, which I shall or may have against them or any

one or more of the arising out of, or in connection with, my child's participation in Camp Celiac's program and its activities, including, but not limited to, for an personal injury that my child may suffer while participating in Camp Celiac's program and activities.

I understand and agree on behalf of my child that my child shares the responsibility for safety during Camp Celiac's program activities, and I personally assume on behalf of my child that responsibility.

I understand and certify that my child's participation in Camp Celiac's program and its activities is completely voluntary, and that I have become familiar with the program activities in which my child may participate as described in any agreement, newsletter, camp brochure or information packet.

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Parent/Legal Guardian's Signature	Printed Name	Date
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Camp Celiac Participant's Printed Name

**Camp Celiac/Celiac Support Group For Children, Inc. Photograph Permission**

*I give permission for photographs or videos of my camper to be used in Camp Celiac/Camp Aldersgate promotional literature including, but not limited to video, calendars, slide shows or website.*

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**Signature of Parent/Guardian Date**

**Camp Celiac Zero Tolerance Policy**

For the safety of your child and all persons at camp, Camp Celiac cannot and will not tolerate any of behaviors listed below.

I understand and have advised my child (person for whom I am guardian or responsible) that the following will require him/her to leave camp prematurely. There will be no refunds.

1. Smoking, drinking, use or possession of illegal substances.
2. Climbing out of windows or leaving sleeping areas after lights out for other than lavatory.
3. Possession of any weapon or anything intended to be used as a weapon and/or all physical violence.
4. Bullying, harassing, or intimidating other campers and staff.

**Signature of Parent/Guardian:**

**Date:** \_\_\_\_\_

**Signature of Camper:**

**Date:** \_\_\_\_\_

**HEALTH HISTORY AND EXAMINATION FORM FOR CHILDREN, YOUTHS AND ADULTS ATTENDING CAMP CELIAC**

*(Everyone must have had a complete physical examination within 12 months of entrance to camp.)*

Mail this form to: Mrs. Tanis Collard, CSGC, Inc., 11 Level Acres Rd., Attleboro, MA 02703

*The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. This form, except for the "Health Recommendations of a Licensed Medical Personnel", to be filled in by parent/guardians of minors or by adults themselves.*

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_ Age at Camp: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Custodial Parent/Guardian: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Work Telephone: \_\_\_\_\_

Second Parent/Guardian: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Work Telephone: \_\_\_\_\_

**IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY:**

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

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**INSURANCE INFORMATION**

Is the participant covered by family medical/hospital insurance? YES \_\_\_\_\_ NO \_\_\_\_\_

If so, indicate carrier or plan name: \_\_\_\_\_

Carrier Address: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_

**IMPORTANT! THIS AREA MUST BE COMPLETE FOR ATTENDANCE PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE:**

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

Signature of parent/guardian or adult staffer: \_\_\_\_\_ Date: \_\_\_\_\_

## HEALTH HISTORY

**THE FOLLOWING INFORMATION MUST BE FILLED IN BY THE PARENT/GUARDIAN/ADULT STAFFER. ANY CHANGES TO THIS FORM SHOULD BE PROVIDED TO CAMP HEALTH PERSONNEL UPON PARTICIPANT'S ARRIVAL IN CAMP. PROVIDE COMPLETE INFORMATION SO THAT THE CAMP CAN BE AWARE OF YOUR NEEDS.**

Medication Allergies:

Describe Reaction & Treatment:

_____	_____
_____	_____
_____	_____
_____	_____

Food Allergies:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Allergies (Include insect stings, hay fever, asthma, animal dander, etc.):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## MEDICATIONS BEING TAKEN

*Please list ALL medications including over-the-counter or nonprescription drugs taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration. Do not bring medication in daily pill containers. Non-prescription drugs must remain in the original container.*

THIS PERSON TAKES NO MEDICATIONS ON A ROUTINE BASIS: \_\_\_\_\_

THIS PERSON TAKES MEDICATIONS AS FOLLOWS:

MED. #1 \_\_\_\_\_ DOSAGE \_\_\_\_\_ TIMES PER DAY \_\_\_\_\_  
REASON FOR TAKING: \_\_\_\_\_

MED. #2 \_\_\_\_\_ DOSAGE \_\_\_\_\_ TIMES PER DAY \_\_\_\_\_  
REASON FOR TAKING: \_\_\_\_\_

MED. #3 \_\_\_\_\_ DOSAGE \_\_\_\_\_ TIMES PER DAY \_\_\_\_\_  
REASON FOR TAKING: \_\_\_\_\_

ASIDE FROM THE GLUTEN-FREE DIET, PLEASE LIST ANY OTHER SPECIAL DIETARY RESTRICTIONS: \_\_\_\_\_

EXPLAIN ANY RESTRICTION TO ACTIVITY (EG. WHAT CANNOT BE DONE, LIMITATIONS):  
\_\_\_\_\_  
\_\_\_\_\_

**GENERAL QUESTIONS (EXPLAIN YES ON LINE PROVIDED)**

HAS/DOES THE PARTICIPANT :

YES OR NO

- 1 Had any recent injury, illness or infectious disease or trauma during the past year? \_\_\_\_\_
- 2 Have a chronic or recurring illness/condition? \_\_\_\_\_
- 3 Ever been hospitalized? \_\_\_\_\_
- 4 Have frequent headaches? \_\_\_\_\_
- 5 Ever had surgery? \_\_\_\_\_
- 6 Ever had a head injury? \_\_\_\_\_
- 7 Wear glasses, contacts or protective eyewear? \_\_\_\_\_
- 8 Ever been knocked unconscious? \_\_\_\_\_
- 9 Ever had frequent ear infections? \_\_\_\_\_
- 10 Ever passed out during or after exercise? \_\_\_\_\_
- 11 Ever been dizzy during or after exercise? \_\_\_\_\_
- 12 Ever had seizures? \_\_\_\_\_
- 13 Ever had chest pain during or after exercise? \_\_\_\_\_
- 14 Ever had high blood pressure? \_\_\_\_\_
- 15 Ever been diagnosed with a heart murmur? \_\_\_\_\_
- 16 Ever had back problems? \_\_\_\_\_
- 17 Ever had problems with joints (eg. , knees, ankles)? \_\_\_\_\_
- 18 Have an orthodontic appliance being brought to camp? \_\_\_\_\_
- 19 Have any skin problems (eg., itching, rash, acne)? \_\_\_\_\_
- 20 Have diabetes? \_\_\_\_\_
- 21 Have asthma? \_\_\_\_\_
- 22 Had mononucleosis in the past 12 months? \_\_\_\_\_
- 23 Had any problems with diarrhea/constipation? \_\_\_\_\_
- 24 Have any problems sleepwalking? \_\_\_\_\_
- 25 If female, have an abnormal menstrual cycle? \_\_\_\_\_
- 26 Have a history of bed-wetting? \_\_\_\_\_
- 27 Have an eating disorder? \_\_\_\_\_
- 28 Ever had emotional difficulties for which professional help was sought? \_\_\_\_\_
- 29 Sunburn easily? \_\_\_\_\_
- 30 Has camper been exposed to a contagious disease or been ill within the last 3 weeks? \_\_\_\_\_

PLEASE EXPLAIN ANY "YES" QUESTIONS AND NOTE THE QUESTION NUMBER:  
\_\_\_\_\_  
\_\_\_\_\_

WHICH OF THE FOLLOWING ILLNESSES HAS THE PARTICIPANT HAD?

- \_\_\_\_ Measles
- \_\_\_\_ Chicken Pox
- \_\_\_\_ German Measles
- \_\_\_\_ Mumps
- \_\_\_\_ Hepatitis (Type \_\_\_\_\_)
- \_\_\_\_ Varicella Zoster (Shingles)

PLEASE GIVE THE DATE FOR LAST IMMUNIZATION FOR:

- DPT
- TD (Tetanus/Diphtheria)
- Tetanus
- Polio
- Measles (hard or red measles or rubeola)
- Rubella (German Measles)
- Haemophilus influenza B
- Hepatitis B
- Date of last TB Mantoux test (Results \_\_\_\_\_)

*Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.*

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Name of family physician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATIONS: THIS HEALTH HISTORY IS CORRECT AND COMPLETE AS FAR AS I KNOW, AND THE PERSON HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL CAMP ACTIVITIES EXCEPT AS NOTED.**

**SIGNED:** \_\_\_\_\_  
**PRINTED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**TO BE COMPLETED BY YOUR DOCTOR/LICENSED HEALTH CARE PROVIDER  
(MUST BE WITHIN THE PAST 12 MONTHS)**

**HEALTH CARE RECOMMENDATIONS**

NAME OF PARTICIPANT \_\_\_\_\_

I have examined the above camp participant. Date of last examination \_\_\_\_\_

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant \_\_\_\_\_ is \_\_\_\_\_ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions \_\_\_\_\_

Current treatment at the time of this report includes \_\_\_\_\_

**RECOMMENDATIONS AND RESTRICTIONS AT CAMP**

Treatment to be continued at camp \_\_\_\_\_

Medications to be administered at camp (name, dosage, frequency) \_\_\_\_\_

Any medically-prescribed meal plan or dietary restrictions \_\_\_\_\_

Known allergies \_\_\_\_\_

Description of any limitation or restriction on camp activities \_\_\_\_\_

Additional information for health care staff at camp \_\_\_\_\_

**SIGNATURE OF LICENSED MEDICAL PERSONNEL**

PRINTED \_\_\_\_\_ TITLE \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_ DATE \_\_\_\_\_

**FOR CAMP USE ONLY**

**DATE SCREENED** \_\_\_\_\_

**MEDS RECEIVED** \_\_\_\_\_

**OBSERVATIONAL NOTES** \_\_\_\_\_

**DATE** \_\_\_\_\_ **SEEN FOR** \_\_\_\_\_

**DATE** \_\_\_\_\_ **SEEN FOR** \_\_\_\_\_

**DATE** \_\_\_\_\_ **SEEN FOR** \_\_\_\_\_